

“My Migraine” Descriptive Checklist

Headache Onset

Fill in Date: (mm/dd/yyyy) __ / __ / ____

Time Began: __ : __ AM or PM (Circle one)

Time Ended: __ : __ AM or PM (Circle one)

.....

Preceding Symptoms

(Please circle one)

Visual disturbances or aura? YES or NO

Motor Disturbances? YES or NO

Numbness/tingling? YES or NO

Other Symptoms? YES or NO

If yes please explain:

Headache Symptoms

Headache Pain severity scale (1= not severe, 5= most severe) (circle one)

1 2 3 4 5

Description of pain (throbbing, stabbing, beating, pounding, dull ache, pulsating, hammering, twinging, etc.)

Location of pain

Other symptoms (nausea, sensitivity to light, vomiting, sensitivity to sound...)

Headache Treatment

What medications have you taken and in what amount?

Effectiveness scale (1= not effective, 5= most effective) (circle one)

1 2 3 4 5

How long did it take to work?

Non-medical treatments (sleep, darkness, heat, cold compress, ice, relaxation techniques, etc.)

Possible Triggers

(Check all that apply)

Changes in eating patterns

Food/Drink

Environmental (light, odors, noises, weather)

Emotion (stress, anger, depression, fatigue, anxiety)

Activity

Medications

Hormonal (birth control, estrogen supplements association with menstruation)

Other (If so, please explain)

If you have any other comments or concerns please list them below.
