MY MIGRAINE DIARY

To help discuss your treatment plan with your doctor, fill in the calendar below.
Each time you experience a migraine, indicate the day and record the following:

- Overall intensity/severity of the migraine
- Any migraine symptoms
- Time at which you took medication
- When you first felt relief
- Hours of bedrest required before the attack was over
- Hours until you were able to resume work or life activities

MONTH _____

Day (circle)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Overall migraine intensity/severity Scale of 0-5. See scale below																															
Migraine symptoms (indicate symptoms)																															
Aura																															
Throbbing																															
Nausea																															
Sensitivity to light																															
Sensitivity to sound																															
Other:																															
How quickly did you take take your medication? (check one)																															
Immediately (first sign)																															
Within 30-60 minutes																															
After 1 hour																															
What medication did you take?																															
When did you first experience relief after taking your medication? (check one)																															
Within 15 minutes																															
16-30 minutes																															
31-60 minutes																															
More than 1 hour																															
Hours of bedrest required																															
Able to work/function (yes/no)																															
Returned to work/activities on the same day (yes/no)																															

0 = no pain; **1** = mild pain; **2** = troublesome pain; **3** = distressing pain; **4** = intense pain; **5** = worst possible pain

DEPOMED