

# MY MIGRAINE DIARY



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20804416(2)-05/08-MAX Printed in USA Minimum 10% Recycled Paper

## MIGRAINE ATTACK

Date of attack: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_ Activity: \_\_\_\_\_

Medication used: \_\_\_\_\_ Duration of pain: \_\_\_\_\_

Was the pain:  Mild  Moderate  Severe  Worsened by activity

Symptoms:  Aura  Nausea  Vomiting  Sensitivity to light  
 Sensitivity to sound

Possible triggers (eg, menstruation, foods, medications): \_\_\_\_\_

Additional notes: \_\_\_\_\_

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