

My migraine diary

for therapy support

Last name/first name

MY MIGRAINE DIARY FOR

September 2019

Month/year

DAY	1	2	3	4	5	6
In the morning	0	0	1	2	0	0
At noon	1	0	2	1	0	0
In the evening	1	1	3	0	0	0

Prophylaxis:
Example name X

Acute medication X X

Menstruation X

High stress level due to

Annotations

Dear migraine sufferer,

this diary for therapy support serves to assess the success of your medicinal migraine therapy. It's quite simple:

1. Please note the corresponding **month** and **year** (e.g. September 2019)
2. Now enter for each day how you felt your migraine in the morning, at noon and in the evening:
0: Completely free of headaches
1: Headaches that didn't **impaired** me in my activities
2: Headaches that have **moderately impaired** me in my activities
3: Knock-out headaches that have **severely impaired** me in my activities (e.g. need for a dark room, retreat or absolute rest; severe impairment of daily activities)
3. Please enter the name of your **prophylactic medication** and how it is used in this line.
4. In this line, please mark the days on which you have taken an **acute headache medication**.
5. Here, please mark the days on which you had your **menstruation**.
6. In the **annotations** you can note other things that are important to you or that you would like to discuss during your next visit to the physician.

Please take this diary with you to your appointment with your physician.

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MY MIGRAINE DIARY FOR THERAPY SUPPORT

Last name/first name

Month/year **0:** Free of headache | **1:** Not impaired | **2:** Moderately impaired | **3:** Massively impaired

DAY	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	
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