Peled Plastic Surgery

SAN FRANCISCO & WALNUT CREEK

PATIENT NAME: _____

DATE	MIGRAINE (YES OR NO)	START TIME	END TIME	TOTAL TIME	INTENSITY (0-10) 0 = NO PAIN, 10= WORST PAIN	LOCATION: ABOVE EYEBROWS, TEMPLE(S), BACK OF NECK, OTHER	ASSOCIATED SYMPTOMS (i.e.. NAUSEA, VOMITING)	DID ANYTHING BRING ON OR MAKE YOUR HEADACHE WORSE (i.e. STRESS, BRIGHT LIGHTS)
Ex.	*Y*	*11 AM*	*3PM*	*4 hrs*	*8*	*Back of neck on right*	*Nausea, lightheaded*	*Chocolate, sunshine*

MIGRAINE LOG

525 SPRUCE STREET, SUITE #2, SAN FRANCISCO, CA 94118
365 LENNON LANE, SUITE #250, WALNUT CREEK, CA 94598
(P) 415-751-0583 (P) 925-933-5700 (F) 415-751-6814