MIGRAINE TRIGGER LOG

Month/Year: _____
Patient Name:
Primary Physician:
Observation Period:

DATE/TIME	FOOD/DRINK CONSUMED	INGREDIENTS OF NOTE (CAFFEINE, TYRAMINE, MSG)	ONSET TIME (HOURS AFTER MEAL)	SEVERITY (1-10)	SYMPTOMS/NOTES

Severity Scale: 1-3 Mild (Manageable) 4-6 Moderate (Interferes with activity) 7-10 Severe (Requires bed rest/ER)

Additional Observations:

(Hydration levels, sleep quality, stress factors, or weather changes during this period)

This document is for personal tracking only. Consult a medical professional for diagnosis.