MASSACHUSETTS GENERAL HOSPITAL
PLASTIC AND RECONSTRUCTIVE SURGERY

Migraine Pain Location

Name: _____ **Date:** _____

Date of birth: _____

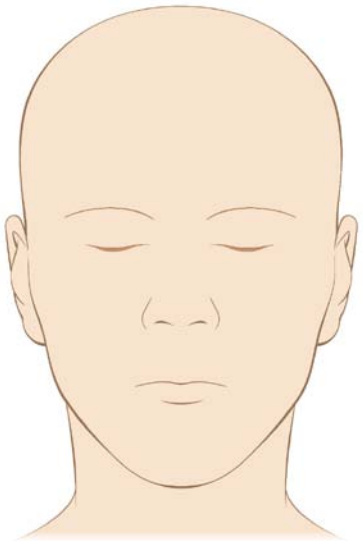
Instructions:

1. Please mark where your pain starts in **black**
2. Please mark if/where your pain travels in **any other color**
3. Scan or take a picture of this form (in color) and email it to EYDUNN@mgh.harvard.edu. You may also mail this form to:

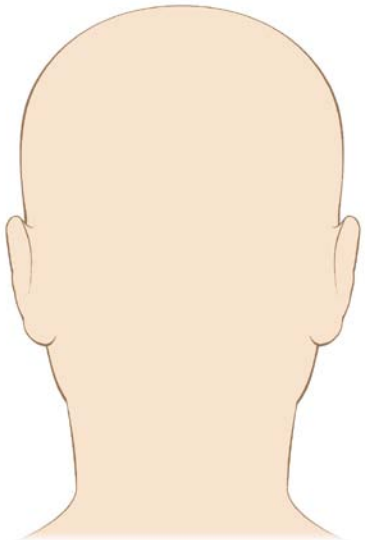
   William G. Austen, Jr., MD
   Attn: Elizabeth Dunn
   Massachusetts General
   Hospital 55 Fruit Street, Wang
   435 Boston, MA 02114

   If you have any questions, please call 617-724-9922.

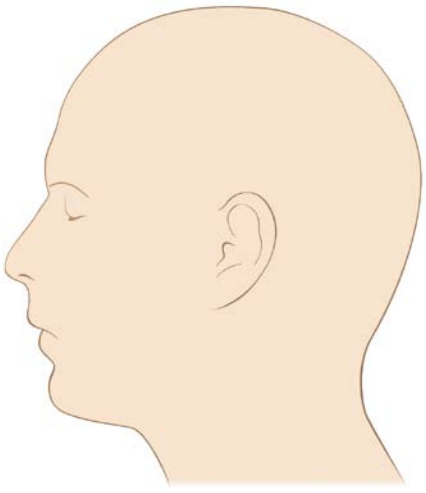
Front



Back



Left Side



Right Side