MY HEADACHE DIARY

This diary will help you keep track of your headaches over the next 3 months. Using it every day over this time will give your doctor a more accurate picture of your headaches. If your headaches are frequent or severe, or you're not getting the relief you need, see your doctor before the end of 3 months.

CHRONIC
MIGRAINE HELP

MY HEADACHE DIARY

SAMPLE

Use this diary **every day** to capture information that can help you and your doctor better understand, and manage, your headaches. Each diary sheet is for one month, with a column for each day of the month. Below is a **sample diary** to show you how to use it.

DATE	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
Did you have a headache today?				✓												✓															
Duration of headache? (in hours)				2										2												5					
Menstruation (if applicable)											✓	✓										✓						✓			

Headache Severity

For each day you experienced a headache, please specify how severe your headache was. If you experienced more than one headache in a day, select the greatest severity.

Mild = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

DATE	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
Mild				✓												✓															
Moderate					✓														✓												
Severe										✓	✓														✓			✓			

DATE	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
Site of pain																															
One side only																															
Both sides																															
Type of pain																															
Throbbing/ pulsing										✓	✓											✓					✓				
Pressing/ squeezing																															
None of the above																															
Headache symptoms																															
Aggravated by physical activity																															
Nausea																															
Vomiting																															
Light sensitivity													✓																		
Noise sensitivity																															
Unable to work/function																															
Medications taken																															

MY HEADACHE DIARY

Name: _____ Month: _____ Year: _____

Date of next doctor's appointment: _____

DATE	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
Did you have a headache today?																															
Duration of headache? (in hours)																															
Menstruation (if applicable)																															

Headache Severity

Mild = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

DATE	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
Mild																															
Moderate																															
Severe																															

DATE	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
Site of pain																															
One side only																															
Both sides																															
Type of pain																															
Throbbing/ pulsing																															
Pressing/ squeezing																															
None of the above																															
Headache symptoms																															
Aggravated by physical activity																															
Nausea																															
Vomiting																															
Light sensitivity																															
Noise sensitivity																															
Unable to work/function																															
Medications taken																															

MY HEADACHE DIARY

Name: _____ Month: _____ Year: _____

Date of next doctor's appointment: _____

DATE	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
Did you have a headache today?																															
Duration of headache? (in hours)																															
Menstruation (if applicable)																															

Headache Severity

Mild = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

DATE	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
Mild																															
Moderate																															
Severe																															

DATE	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
Site of pain																															
One side only																															
Both sides																															
Type of pain																															
Throbbing/ pulsing																															
Pressing/ squeezing																															
None of the above																															
Headache symptoms																															
Aggravated by physical activity																															
Nausea																															
Vomiting																															
Light sensitivity																															
Noise sensitivity																															
Unable to work/function																															
Medications taken																															

MY HEADACHE DIARY

Name: _____ Month: _____ Year: _____

Date of next doctor's appointment: _____

DATE	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
Did you have a headache today?																															
Duration of headache? (in hours)																															
Menstruation (if applicable)																															

Headache Severity

Mild = Noticeable **Moderate** = Cannot be ignored **Severe** = As bad as it could be

DATE	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
Mild																															
Moderate																															
Severe																															

DATE	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
Site of pain																															
One side only																															
Both sides																															
Type of pain																															
Throbbing/ pulsing																															
Pressing/ squeezing																															
None of the above																															
Headache symptoms																															
Aggravated by physical activity																															
Nausea																															
Vomiting																															
Light sensitivity																															
Noise sensitivity																															
Unable to work/function																															
Medications taken																															

For more information visit

chronicmigrainehelp.com.au

CHRONIC
MIGRAINE HELP

Allergan Australia Pty Ltd. 810 Pacific
Highway, Gordon NSW 2072. ABN 85 000 612 831. Allergan New Zealand Limited, Auckland.
NZBN 94 290 3212 0141. © 2019 Allergan. All rights reserved.
Date of Preparation: September 2019 AN-BTX-1950010 V2 DA number: DA1907CB