Migraine / Headache Diary

From:_____ To:_____

Print this migraine and/or headache diary and use it to keep track of your headaches or migraines.

Date:	Date:	Date:	Date:	Date:	Date:	Date:
Warning Signs:	Warning Signs:	Warning Signs:	Warning Signs:	Warning Signs:	Warning Signs:	Warning Signs:
Time Begun:	Time Begun:	Time Begun:	Time Begun:	Time Begun:	Time Begun:	Time Begun:
Time Ended:	Time Ended:	Time Ended:	Time Ended:	Time Ended:	Time Ended:	Time Ended:
Type of pain:	Type of pain:	Type of pain:	Type of pain:	Type of pain:	Type of pain:	Type of pain:
Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)	Intensity of pain: 1 2 3 4 5 6 7 8 9 10 (low) (high)
Location:	Location:	Location:	Location:	Location:	Location:	Location:
Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:
Effect of Treatment:	Effect of Treatment:	Effect of Treatment:	Effect of Treatment:	Effect of Treatment:	Effect of Treatment:	Effect of Treatment:
Hours of Sleep:	Hours of Sleep:	Hours of Sleep:	Hours of Sleep:	Hours of Sleep:	Hours of Sleep:	Hours of Sleep:
What I Ate Today:	What I Ate Today:	What I Ate Today:	What I Ate Today:	What I Ate Today:	What I Ate Today:	What I Ate Today:
Unusual Events or Comments:	Unusual Events or Comments:	Unusual Events or Comments:	Unusual Events or Comments:	Unusual Events or Comments:	Unusual Events or Comments:	Unusual Events or Comments: