Month/Year

Patient Name
Patient Number

Headache Diary

Day	Menses	Headache Onset#	Headache intensity *	Comments@
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
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18				
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21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

#Time of headache
*Scale of 1(mild) to 10 (debilitating)
@Life-style changes: sleep, eating, illness, medication