Headache Diary

Name: DOB: Other Medication – Daily prevention – Name: Dose:

Month: Year: Hormonal treatments – Name:

Date	Day of Week	Trigger Event	Severity 0-10 (10= most severe)	Feel Sick? Yes/No	Vomit Yes/No	Medication Tried (Time taken, dose, hormones taken, period)	Barometric Pressure	Better with?
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