



Name: _____ Month/Date: _____

Instructions:

Use this diary to track details of your headaches. You can share this information with your doctor when talking about your condition and treatment plan.

Part 1: Headache severity

Record the strength of your headache pain using an 11-point scale, where 0 = no pain and 10 = the worst pain you have experienced. Provide scores for different times of the day—morning, afternoon, and evening—to see how your headache pain changes.

Part 2: Headache duration

Record how long your headaches last: less than 4 hours, 4 to 12 hours, or 13 to 24 hours.

Part 3: Headache symptoms

Record all symptoms that accompany each headache. Choose from the list provided, or list any other symptoms in the space(s) noted “Other.”

Part 4: Medication use

Record the name and dose of medication used, if any. This includes all acute and preventive medications, both over-the-counter and prescription.

YOUR MIGRAINE DIARY

Part 1: Headache severity (0 = no pain; 10 = the worst pain you have experienced)

Day	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	
Morning																																
Afternoon																																
Evening																																

Part 2: Headache duration (Mark with an "X" how long each headache lasted)

Day	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	
Less than 4 hours																																
4 to 12 hours																																
13 to 24 hours																																

Part 3: Headache symptoms (Mark with an "X" any signs or symptoms experienced with each headache)

Day	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	
Aura																																
Nausea																																
Sensitivity to light																																
Sensitivity to sound																																
Inability to work/function																																
Throbbing																																
Other:																																
Other:																																
Other:																																

Part 4: Medication use (Record the name and dose of medication used, if any)

Day	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	
Medication 1 name:																																
Dosage per day																																
Medication 2 name:																																
Dosage per day																																
Medication 3 name:																																
Dosage per day																																
Medication 4 name:																																
Dosage per day																																

Adapted from the American Headache Society.