MONTH: _____

Name: _____

Headache 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																															

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.

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.

BOTOX® onabotulinumtoxinA

MONTH: _____

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
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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
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Dosage per day																															
Medication 2 Name:																															
Dosage per day																															
Medication 3 Name:																															
Dosage per day																															
Medication 4 Name:																															
Dosage per day																															

MONTH: _____

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																															
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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																															
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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
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Other:																															
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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
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