My Headache Diary

Share this information with your doctor when talking about your condition and treatment plan.

My Headache Diary
Instructions on how to use it

This diary includes 3 months for you to complete. Many physicians feel that 3 months gives a more accurate picture of your headache history. However, please do see your physician *before* the end of the 3 months if your headaches are frequent, severe, or not responding to your current treatment.

NOTE:
When you are asked about the *severity* of your headache, use the following guide:

Mild headache: able to carry out activities **(mild=1)**
Moderate headache: able to carry out activities with difficulty **(moderate=2)**
Severe headache: cancellation of work or social activities **(severe=3)**

SAMPLE

My Headache Diary

Month 1: April **Year:** 2013 **Name:** Christine Smith

About My Headache:

Days of the Month

	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
Rate your headache severity for each day you suffered an attack. (3=severe, 2=moderate, 1=mild)	3	1		2			3	3		2	3	3		1		1				3	3	3		1			2		2	3	
Did you have an aura before your attack? (yes [Y] / no [N])	Y	N		N			Y	N		Y	Y	N		N		N				Y	N	Y		N			Y		Y	Y	
Did the pain interrupt your day? (yes [Y] / no [N])	Y	N		Y			Y	Y		Y	Y	Y		N		N				Y	Y	Y		N			Y		Y	Y	

Total attacks or interrupted days: 17

Total number of days with aura: 9

Total number of days interrupted by headache: 13

About My Headache Treatment:

List the medications you take to treat your headache. Enter the number of doses you take each day.

Days of the Month

Rate the relief provided by each medication. (N=none, L=mild, M=moderate, C=complete)

Medication/Strength (mg/units):	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	Total doses
Ibuprofen, 200mg	2							1												4							3		3	1		14
Relief provided by medication:	L							M												N							L		N	C		
Sumatriptan, 50mg				1						1	1											2										5
Relief provided by medication:				M						M	M											L										
Acetaminophen, 500mg								2				3										1								1		7
Relief provided by medication:								L				N										C								M		
BOTOX (155 U)																																
Relief provided by medication:																																
Did your headache return after it was first relieved? (yes [Y] / no [N])	Y			Y				N		Y	Y	N								N	N	Y					N		N	Y		
Did you have any side effects from the medication? (yes [Y] / no [N])	Y			Y				Y		Y	N	N								Y	N	N					Y		Y	N		

About My Headache Triggers:

List the triggers you think may cause your headaches. Check off any day these triggers occur.

Days of the Month

Triggers:	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
1. Alcohol	✓							✓												✓											
2. Weather change				✓						✓	✓									✓	✓	✓					✓		✓		
3. Food (chocolate)								✓				✓										✓					✓		✓	✓	
4. Stress/tension												✓															✓		✓	✓	
5.																															
6.																															
7.																															
If you are a woman, check off the dates of your menstrual period.									X	X	X	X	X																		

After you have completed the entire calendar month, please answer the following questions based on the totals above:

This month, my total number of days with headache was: 17 days.

This month, my total number of interrupted days due to headache was: 13 days.

This month, my total number of pills taken due to headache was: 28 pills.

You may be a candidate for preventative headache treatment *(to reduce the frequency and severity of your headache)* **if:**

a. your headaches are disrupting your quality of life, and/or

b. you have three or more severe headache attacks per month that fail to respond to therapy.

[X] **Check here if you would like to discuss headache prevention with your doctor.**

BOTOX® onabotulinumtoxinA

For more information about BOTOX® and Chronic Migraine, visit www.BOTOX.ca and enter the drug identification number (DIN) 01981501.

My Headache Diary

Month 1: ____________ **Year:** ________ **Name:** ______________________

About My Headache:

Days of the Month

	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
Rate your headache severity for each day you suffered an attack. (3=severe, 2=moderate, 1=mild)																															
Did you have an aura before your attack? (yes [Y] / no [N])																															
Did the pain interrupt your day? (yes [Y] / no [N])																															

Total attacks or interrupted days: ______

Total number of days with aura: ______

Total number of days interrupted by headache: ______

About My Headache Treatment:

List the medications you take to treat your headache. Enter the number of doses you take each day.

Days of the Month

Rate the relief provided by each medication. (N=none, L=mild, M=moderate, C=complete)

Medication/Strength (mg/units):	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	Total doses
Relief provided by medication:																																
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Relief provided by medication:																																
Did your headache return after it was first relieved? (yes [Y] / no [N])																																
Did you have any side effects from the medication? (yes [Y] / no [N])																																

About My Headache Triggers:

List the triggers you think may cause your headaches. Check off any day these triggers occur.

Days of the Month

Triggers:	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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2.																															
3.																															
4.																															
5.																															
6.																															
7.																															
If you are a woman, check off the dates of your menstrual period.																															

After you have completed the entire calendar month, please answer the following questions based on the totals above:

This month, my total number of days with headache was: ____________ days.

This month, my total number of interrupted days due to headache was: ____ days.

This month, my total number of pills taken due to headache was: ________ pills.

You may be a candidate for preventative headache treatment *(to reduce the frequency and severity of your headache)* **if:**

a. your headaches are disrupting your quality of life, and/or

b. you have three or more severe headache attacks per month that fail to respond to therapy.

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My Headache Diary

Month 2: ______________ **Year:** ________ **Name:** ______________________

About My Headache:

Days of the Month

	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	
Rate your headache severity for each day you suffered an attack. (3=severe, 2=moderate, 1=mild)																																Total attacks or interrupted days
Did you have an aura before your attack? (yes [Y] / no [N])																																Total number of days with aura
Did the pain interrupt your day? (yes [Y] / no [N])																																Total number of days interrupted by headache

About My Headache Treatment:

List the medications you take to treat your headache. Enter the number of doses you take each day.

Days of the Month

Rate the relief provided by each medication. (N=none, L=mild, M=moderate, C=complete)

Medication/Strength (mg/units):	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	Total doses
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Did your headache return after it was first relieved? (yes [Y] / no [N])																																
Did you have any side effects from the medication? (yes [Y] / no [N])																																

About My Headache Triggers:

List the triggers you think may cause your headaches. Check off any day these triggers occur.

Days of the Month

Triggers:	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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If you are a woman, check off the dates of your menstrual period.																															

After you have completed the entire calendar month, please answer the following questions based on the totals above:

This month, my total number of days with headache was: ____________ days.
This month, my total number of interrupted days due to headache was: ____ days.
This month, my total number of pills taken due to headache was: ________ pills.

You may be a candidate for preventative headache treatment *(to reduce the frequency and severity of your headache)* if:

a. your headaches are disrupting your quality of life, and/or
b. you have three or more severe headache attacks per month that fail to respond to therapy.

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My Headache Diary

Month 3: ____________ **Year:** ________ **Name:** ____________________

About My Headache:

Days of the Month

	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	Totals	
Rate your headache severity for each day you suffered an attack. (3=severe, 2=moderate, 1=mild)																																Total attacks or interrupted days	
Did you have an aura before your attack? (yes [Y] / no [N])																																Total number of days with aura	
Did the pain interrupt your day? (yes [Y] / no [N])																																Total number of days interrupted by headache	

About My Headache Treatment:

List the medications you take to treat your headache. Enter the number of doses you take each day.

Days of the Month

Rate the relief provided by each medication. (N=none, L=mild, M=moderate, C=complete)

Medication/Strength (mg/units):	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	Total doses
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Did your headache return after it was first relieved? (yes [Y] / no [N])																																
Did you have any side effects from the medication? (yes [Y] / no [N])																																

About My Headache Triggers:

List the triggers you think may cause your headaches. Check off any day these triggers occur.

Days of the Month

Triggers:	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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If you are a woman, check off the dates of your menstrual period.																															

After you have completed the entire calendar month, please answer the following questions based on the totals above:

This month, my total number of days with headache was: ____________ days.
This month, my total number of interrupted days due to headache was: ____ days.
This month, my total number of pills taken due to headache was: ________ pills.

You may be a candidate for preventative headache treatment *(to reduce the frequency and severity of your headache)* **if:**

a. your headaches are disrupting your quality of life, and/or
b. you have three or more severe headache attacks per month that fail to respond to therapy.

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BOTOX® onabotulinumtoxinA

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visit **www.BOTOX.ca** and enter the drug identification number (DIN) 01981501.

BOTOX® (onabotulinumtoxinA for injection) is indicated for the prophylaxis of headaches in adults with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer).[1]

Consult the product monograph at http://webprod5.hc-sc.gc.ca/dpd-bdpp/index-eng.jsp for important information about:

- The most serious warning and precaution regarding the units representing BOTOX® activity, which is unique to Allergan's formulation of botulinum toxin type A and therefore are not interchangeable with other products.[1]
- Other relevant warnings and precautions regarding adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, difficulty with swallowing, speech or respiratory disorders, anaphylactic reaction, use in children and adolescents under 18 years of age, use in pregnant and nursing women.[1]
- Conditions of clinical use, adverse reactions, drug interactions and dosing instructions.

The product monograph is also available through our medical department. Call us at 1-800-668-6424.

1. BOTOX® Product Monograph, Allergan Inc., October 10, 2013.

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