Migraine / Headache Calendar

Name: ____ Category: M=Migraine / H=Headache / P=Period (if applicable)

- Scoring: Migraine/Headache - 0-10 (0=No pain, 10=The worst pain you have experienced)
- Mark type of medication used under Medication column (see legend, ex T, N) | • Black or Blue Ink Only Please

Month:

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	
Category																																
M/H Score																																
Medication																																Totals M: H:

Month:

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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Month:

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Category																																
M/H Score																																
Medication																																Totals M: H:

Medication Legend:

T = Triptan O = Opioid N = NSAID G = Gepant D = Device

A = Acetaminophen (Tylenol) B = Barbiturate (Fiorocet) X = Other

Other (write in):

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