Capital Health PLAN

PATIENT NAME: _____   **DOB:** _____

A current log with a minimum of (3) full months is required when submitting the Patient Headache Diary to CHP

In the corresponding block please enter the following information:

CATEGORY= The type of Headache or Migraine you had- **M**= Migraine, **H**=Headache, **O**= No Headache or Migraine

DURATION= The number of hours that you had a Headache or Migraine for that day

AURA= Did you have an Aura with your Headache or Migraine- **Y**=Yes, **N**=No

MONTH and YEAR _____

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																															
DURATION																															
AURA																															

MONTH and YEAR _____

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