# What preventive medications have you tried in the past for your headaches?

| Medication name | Maximum dose of the medication you used | When were you on this drug? | Why was it stopped? | Were you taking more than 8 days a month of painkillers or triptans when on this drug? |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |