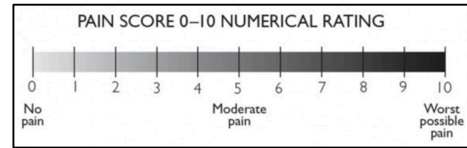
HEADACHE DIARY



Name : ___________________________________ Month: __________________________ Year:______________________

HEADACHE SEVERITY

HEADACHE SEVERITY DURATION	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
9-10																															
7-8																															
5-6																															
3-4																															
1-2																															

Severity : 1-2 for mildest and 9-10 for most severe Shade for duration e.g. : ½ in AM ½ in PM Whole day Midday

DISABILITY FOR THE DAY

DATE	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
DISABILITY FOR THE DAY																															

0 = None 1= Able to carry out usual activities fairly well 2= Difficulty with usual activity, may cancel less important ones 3= Have to miss work (all or part of the day) or go to bed for part of day

MENSTRUAL PERIODS. For females put an X on days you have menstruation

DATE	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
MENSTRUAL PERIODS																															

ACUTE MEDICATIONS (Tablets/Injections) (Medications to treat headache e.g triptans, NSAIDs, tramadol, painkillers, etc) Put the # of tablets on the date you took the medicine and below it, the overall effect on your headache

DATE	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
Name _______________/______mg																															
Overall Relief																															
Name _______________/______mg																															
Overall Relief																															

Relief 0-1-2-3 0 = None 1= Slight Relief 2 = Moderate Relief 3 = Complete Relief

PREVENTIVE MEDICATIONS (Daily medications taken to prevent or decrease your headache tendency, e.g. propranolol, amitriptyline, topiramate, flunarizine, valproate etc). As this is to ensure compliance, put an **X** on the date if you take the medicine.

DATE	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
Name /mg																															
Name /mg																															

TRIGGERS

DATE	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
TRIGGERS																															

1.____________________________. 2.___________________________ 3.___________________________ 4.___________________________

Please code trigger with a number and give details below. Record trigger number in table above on the appropriate date when you feel the trigger contributed to your headache.
You may put several triggers on a date, as needed.

Instructions: For your doctor to understand and be able to help you, please take the time to fill-up this headache diary. Fill this up if you have an attack of headache. Write at the back of this paper any observations you may like to share. Keep this sheet of paper and show this on your next follow-up.