

Headache Diary days 1-16

Name _____ Month _____ Year _____

Symptoms: N = nausea or vomiting · L = light hurts · S = sound hurts · A = aura (vision or other changes before the pain)

Helped? Did the medicine ease the pain within 2 hours?

Day	Headache? Yes / No	Started time	Lastest hours	Severity 0 = none, 10 = worst	Symptoms circle	Medicine and dose and time taken	Helped? circle	Sleep hours	Before it started meals, caffeine, alcohol, stress, screens, weather, period
1	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
2	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
3	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
4	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
5	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
6	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
7	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
8	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
9	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
10	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
11	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
12	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
13	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
14	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
15	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
16	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		

Fill in a row every day, also on days without a headache.

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Headache Diary

days 17–31

Name _____

Month _____

Year _____

Symptoms: N = nausea or vomiting · L = light hurts · S = sound hurts · A = aura (vision or other changes before the pain)

Helped? Did the medicine ease the pain within 2 hours?

Day	Headache? Yes / No	Started time	Lasted hours	Severity 0 = none, 10 = worst	Symptoms circle	Medicine and dose and time taken	Helped? circle	Sleep hours	Before it started meals, caffeine, alcohol, stress, screens, weather, period
17	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
18	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
19	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
20	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
21	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
22	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
23	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
24	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
25	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
26	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
27	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
28	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
29	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
30	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		
31	Y / N			0 1 2 3 4 5 6 7 8 9 10	N L S A		No Some Yes		

Fill in a row every day, also on days without a headache.

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This month in numbers

Headache days _____

Severe days (severity 7–10) _____

Days I took any pain medicine _____

Days I took a triptan or combination painkiller _____

Days I missed work, school or plans _____

Longest headache (hours) _____

Patterns I noticed

Look at the notes for the day before each headache. What shows up again and again?

Questions for my doctor

How to fill in each day

- Fill in a row **every day**, also on days without a headache. Those days are the comparison that shows patterns.
- Write the start time and severity **during the headache** if you can. They are the easiest details to forget.
- Write every medicine and dose, and whether it helped.
- In the notes, write what happened in the hours before: sleep, meals, caffeine, alcohol, stress, screens, weather, your period.
- Keep going for at least **two months** before you decide what your triggers are.

Severity scale

- | | |
|---------------------|---|
| 0 | No pain |
| 1–3 Mild | You notice it, but you can do your normal day |
| 4–6 Moderate | It gets in the way; you slow down or stop some things |
| 7–10 Severe | You cannot do your normal day; you may need to lie down |

Watch your medicine days

Taking headache medicine too often can cause more headaches (medication-overuse headache). Talk to your doctor if you take a triptan or combination painkiller on 10 or more days a month, or a simple painkiller on 15 or more days a month.

Get medical help right away if

- a headache comes on suddenly and is the worst you have ever had
- you have a fever and a stiff neck, or a rash
- it follows a blow to the head
- you have weakness, numbness, confusion, slurred speech or loss of vision