



Patient Headache Diary

Patient Headache Diary Instructions

This diary is designed for you to use at home to track your headaches. Please fill out for every month during the time you have been asked to keep a headache diary. For each day you will write down the following information:

1. **Date:** Record the current month and day.
2. **Medication Use:** Record whether you used “as needed” medications or not. If you did take “as needed” medications, record the medication name and number of times you took medication.
“As needed” medications are those over-the-counter and prescription medicines you take to treat a specific headache. This does not include those medications you take every day regardless of your current symptoms.
3. **Number of Headaches:** Record the number of headaches you had during this day.
4. **Headache Description:** Write down the following details about your headache. Use a separate line for each new headache.
Severity: Record the strength of your headache pain. Use a scale of 0-10, where 0 is no pain and 10 is the worst pain you can imagine. Only use whole numbers such as 1, 2, 3 and not decimals or fractions (7.5 or 7 $\frac{1}{2}$).
 - If you have a single headache that lasts for the entire day, record the average pain level and worst pain level of that headache.
 - If you have more than one headache on a given day, record the average pain level and the worst pain level for each headache.

Duration: Record the length of your headache in hours.

- **Total duration:** Record the length of every headache. If you have more than one headache on a given day, record the total duration of each headache. Do not include time when you are sleeping. (If the duration is less than one hours, still write down one hour).
- **Severe duration:** Record the length of severe headache pain (greater than or equal to 7 on the 0-10 scale) for each headache.

Associated Symptoms:

- **Aura:** Record whether you experienced visual symptoms, tingling of face or hand, or problems with speech or weakness prior to headache.
- **Prodrome:** Record whether you predictably experience any symptoms prior to the onset of headache (e.g. yawning, nausea, sensitivity to light).
- **Nausea:** Record whether you felt like you might vomit during this headache.
- **Vomiting:** Record whether you vomited during this headache.
- **Sensitive to light:** Record whether you became sensitive to light, wanting to avoid bright light, during this headache.
- **Sensitive to sound:** Record whether you became sensitive to sound, wanting to avoid loud sounds, during this headache.
- **One-sided:** Record whether your headache pain was limited to one side of your body.
- **Which side:** If your headache was one-sided, indicate whether it occurred on the R (right) or L (left) side.
- **Throbbing:** Record whether your headache pain was throbbing or pulsating.
- **Made worse by activity:** Record whether your headache was made worse by activity, making you want to rest.

Patient Name: _____



“My head feels like it’s going to explode.”

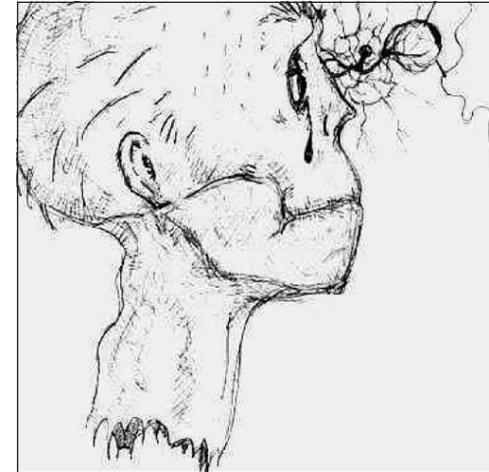
“The left side of my head is splitting from the right.”



“Someone is tightening a vise around my head.”

“Somebody is crushing my skull.”

“Someone is driving spikes into my head.”



“I want to take a spoon and pull my eye out.”

“My eye is popping out.”

Month _____

Date	Severity Avg. / Peak	Duration Total. / Severe	M	S	P	PL	Imploding (I) Ocular (O) Exploding (E)	Nausea		Vomiting		Acute Headache Medication	No. of Doses	Sensitive to Light		Sensitive to Sound		One-Sided		Prodrome*		Aura		Throbbing		Made Worse by Activity		Time To Pain Free	HA Returned	
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***Prodrome:** symptoms that **reliably** warn you that a headache is about to begin (e.g. yawning, fatigue, drowsiness, etc). These symptoms should not include headache pain or neurological symptoms such as visual symptoms (aura) or numbness (aura).

M = Menstruation, S = Spotting, P = Oral Contraceptive Pill, PL = Placebo

Month _____

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