ID : .....
Name : .....
Date : .....
Tel.number : .....
Doctor/Tel.num.: .....

Please, answer the following questions and fill in the headache diary

❶ Did you have today headaches?

Yes = ☹ **No =** ☺

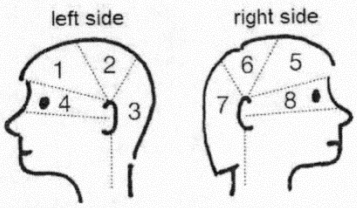
❷ How long did your headaches last?

The whole day = ●
Half of a day = ◑
Less than 2 hours = ○

❸ How severe were your headaches?

Severe = ● Mild = ◑ Light = ○

❹ Where were your headaches?



Please, register the appropriate number in your headache diary

❺ Record the appropriate letters in your headache diary!

A. Did you have nausea/vomiting during headaches?
B. Did you have before or during headaches difficulties with vision?
C. Did you have sensitivity to light during headaches?
D. Did you have sensitivity to sound during the headaches?
E. Did you have any other complains before or during headaches?

❻ Other events that occurred today

Infection - **I**
Stress - **S**
Happiness - **H**
Abdominal pain - **A.P**
Menstruation - **G**

If you took the medicament for your headaches, write down the M in your headache diary!

HEADACHE DIARY

Month:..... Year:.....

	❶	❷	❸	❹	❺	❻
1						
2						
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