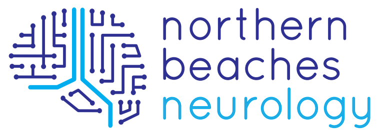

Name: ____________________ Month: __________ Year: __________

Day	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
Do you have a headache?																															
Y/N																															
How bad is the headache? (grade headache out of 10 where 1 is very mild and 10 is the worst possible headache)																															
1 to 10																															
When did the headache start? (Morning = M; day = D; evening = E; overnight = N)																															
M/D/E/N																															
How long did the headache last? (Enter number of hours)																															
hours																															
Headache symptoms? (Mark with X)																															
Sensitive to light/sound																															
Nausea/vomiting																															
Vision changes																															
Dizziness/vertigo																															
Numbness/tingling																															
Weakness																															
Speech change																															
Period?																															
Y/N																															
Headache treatment (write medication name to the left and mark X if used)																															