Headache Diary

Name ____________________ **Menstrual Cycles** *Start* ____________________

Week of ____________________ *Finish* ____________________

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1. Did you have a headache? *If no, skip to question 9.*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Rate your headache pain: *Mild (1-3)* *Moderate (4-6)* *Severe (7-10)*	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10	☐ 1 ☐ 6 ☐ 2 ☐ 7 ☐ 3 ☐ 8 ☐ 4 ☐ 9 ☐ 5 ☐ 10
3. What symptoms did you have?	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms	☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ No symptoms
4. How long did the headache last?	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours	☐ <12 hours ☐ 12-24 hours ☐ 25-48 hours ☐ >48 hours
5. List medication taken for headache and the amount of time to begin providing pain relief.	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins	Medication __________ ____ hrs ____ mins

Froedtert & Medical College of Wisconsin

Migraine Buddy, a tracking app, is available for Android and iPhone.

continued on back

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
6. Rate your ability to work or do other activities.	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised	☐ Mildly compromised ☐ Moderately compromised ☐ Severely compromised
7. Other medications taken?							
8. Hours of sleep last night?							
9. My health today:	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent
10. I feel…	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy	☐ Hopeless ☐ Tired ☐ Downhearted ☐ Nervous ☐ Happy