PERTH MIGRAINE SPECIALIST **HEADACHE DIARY**

PERTH MIGRAINE SPECIALIST

NAME: **DOB:** / / **DATE:** / /

Please answer all questions by placing a tick in the box of the answer that most applies to you and adding the names of the medications you took (if any) that day.
If you did NOT experience a headache on any of these days, please leave the boxes blank and just fill in the medications you have taken (if any).

Date	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
Did you have a headache today?																															
Duration of headache (hours)																															
Menstruation (if applicable)																															
Severity of headache																															
Mild																															
Moderate																															
Severe																															
Site of pain																															
One side only																															
Both sides																															
Type of pain																															
Throbbing/pulsing																															
Pressing/squeezing																															
None of the above																															
Headache Symptoms																															
Aggravated by physical activity																															
Nausea																															
Vomiting																															
Light sensitivity																															
Noise sensitivity																															
Unable to work/function																															
Medications taken																															