

YOUR HEADACHE Calendar/Diary

Month: _____ Year: _____

HEADACHE SEVERITY

The calendar is numbered 1 – 31 for each day of the month. Please record in the box 1-3 or 1-10 to describe your headache pain: 1 = mild; 2 = moderate; 3 = severe or 1-10 with 1 = very mild to 10 = worst possible

Day of Month	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	
Morning																																
Afternoon																																
Evening/Night																																
§ MENSTRUAL PERIOD (X)																																
Duration/Length																																
Day of Month	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	

† DISABILITY FOR THE DAY†

† Disability

Write a number from 0 to 3 that describes how your headache pain affected your activities for the day: 0 = no effect; 1 = able to carry out your activities fairly well; 2 = you had difficulty with usual activities and cancelled less important ones; 3 = you missed work for at least half the day or stayed in bed for part of the day.

§ Menstrual Periods

Place an "X" on the days you have your period.

ACUTE MEDICINES

in (Medicines to treat headaches and related symptoms)

On the days you take medicines to relieve your headache pain write the names of the medicines and the doses in the appropriate box. Place a check (✓) for each dose you take. Also, record a number from 0 to 3 that describes the amount of overall relief you got from the medicine: 0 = no relief; 1 = slight relief; 2 = moderate relief; 3 = complete relief.

Day of Month	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
Medicine: Dose:																															
Overall relief:																															
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Overall relief:																															

PREVENTIVE MEDICINES

(Medicines to prevent headaches)

If your doctor has prescribed medicines for you, check (✓) off the day on the calendar every time you take a medicine.

Day of Month	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
Medicine: Dose:																															
Medicine: Dose:																															
Medicine: Dose:																															

PREVENTIVE LIFESTYLES

Day of Month	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
Exercise:																															
Relaxation performed																															

OVERALL SEVERITY FOR THIS MONTH

Circle one number

0	1	2	3	4	5	6	7	8	9	10
No problem										Almost unbearable

*Adapted with permission from The New England Center for Headache, Stamford, CT
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