Headache Diary

DEUTSCHE MIGRÄNE- UND KOPFSCHMERZ-GESELLSCHAFT

Please indicate which medication you use when suffering from headache:

A:_____

B:_____

C:_____

Month _____

Headache intensity: 0-10
(0= no pain, 10= most severe pain)

Preceding symptoms:
F Flashes or dazzling zigzag lines
G Numbness or abnormal sensation
S Speech impairment
❍ Other symptom:
_____
✱ Another symptom:
_____

Pain duration:
Please indicate pain duration in hours

Headache triggers
1. Agitation or stress
2. Recovery after stress
3. Change of sleeping patterns
4. Menstruation
5. Your personal trigger
_____
6. Another personal trigger
_____

Other symptoms (during headache):
T Lacrimation (tearing)
R Red eyes
N Runny or congested nose

Pain type and location									Other symptoms									Relief by the medication?			
Date	Triggers	Inten-sity	Duration (h)	Throbbing/ stabbing	Pressing	On one side	On both sides	Pre-ceding symp-toms	Vomiting	Nausea	Sensitivity to noise	Sensitivity to light	Sensitivity to odor	Additional symptoms	Medication	Dosage	Yes	No	Somewhat	Date
1																				1
2																				2
3																				3
4																				4
5																				5
6																				6
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