PUGET SOUND NEUROLOGY
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MONTHLY HEADACHE CALENDAR

Name: Month: Year:

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
Headache Severity – *Morning*																															
Afternoon																															
Evening/Night																															

Scale of 0 - 3 No pain = 0 1 2 3 = Pain as bad as it can be

SYMPTOMATIC MEDICATIONS (Tablets/Injections/Nasal Sprays/Suppositories)

Name: Dose:																															
Overall Relief																															
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Relief: 0-1-2-3 0 = None 1 = Slight Relief 2 = Moderate Relief 3 = Complete Relief

PREVENTIVE MEDICATIONS

Name: Dose:																															
Name: Dose:																															
Name: Dose:																															

MENSTRUAL PERIODS																															
TRIGGERS (See Back of Pg.)																															
DISABILITY FOR THE DAY																															

0 = NONE 1 = ABLE TO CARRY OUT ACTIVITIES FAIRLY WELL 2 = DIFFICULTY WITH USUAL ACTIVITY, MAY CANCEL LESS IMPORTANT ONES
3 = HAVE TO MISS WORK (AT LEAST HALF OF THE DAY) OR GO TO BED FOR PART OF THE DAY

PLEASE INDICATE THE OVERALL SEVERITY OF YOUR HEADACHE PROBLEM OVER THE PAST MONTH (CIRCLE ONE):

NO PROBLEM 0 1 2 3 4 5 6 7 8 9 10 VERY BAD (ALMOST UNBEARABLE)

Directions: Record your headache symptoms for each day of the month. Include medications and relief, triggers from the chart below and the impact of your symptoms on day.

Remember to complete one diary for each month and bring to your appointment

THESE DIARIES ARE NECESSARY TO GET YOUR TREAMENT AUTHORIZED BY INSURANCE!

HEADACHE TRIGGERS

Hormones

1. Menses
2. Ovulation
3. Hormone Replacement Therapy

Diet

4. Alcohol
5. Chocolate
6. Aged Cheeses
7. Monosodium Glutamate (MSG)
8. Aspartame (Nutrasweet/Equal)
9. Caffeine
10. Nuts
11. Nitrites, Nitrates
12. Citrus Fruits
13. Other

Changes

14. Weather
15. Seasons
16. Travel
17. Altitude
18. Schedule Changes
19. Sleeping Patterns (Too little/too much)
20. Diet
21. Skipping Meals

Sensory Stimuli

22. Strong Light
23. Flickering Lights
24. Odors

"Stress"

25. Let-Down Periods
26. Intense Activity
27. Loss (Death, Separation, Divorce)
28. Relationship Difficulties
29. Job Loss/Change
30. Crisis
31. Other

KEEPING A DIARY HELPS YOU TO IDENTIFY PATTERNS TO YOUR MIGRAINES.