Headache Diary BPNA 2003

Name: Date of birth: Sex:
Hospital Number:

Attack number	**1**	**2**	**3**	**4**
Date				
Time headache started				
Symptoms before headache				
Severity of headache*				
Type of headache**				
Site of maximum pain				
What started it off?				
Any loss of appetite?				
Nausea?				
Vomiting?				
Does light make it worse?				
Does noise make it worse?				
Does walking make it worse?				
Does rest make it better?				
Does sleep make it better?				
Does medication help?				
Medications taken				
Doses				
Time doses taken				
Time headache resolved				

*Severity: Write 1 if you can carry on as usual
Write 2 if you have to cut down some activities
Write 3 if you have to stop everything and just lie down

**Type of pain: Choose one of the following or your own description: Dull, just "Sore", "Throbbing" or "Banging", "Sharp", Pressure or Tightness