Kijabe OPD Patient Information

Headache Diary

Name: ________________________________

Date	Headache pain score (score 0 if no pain, 10 for worst)	Duration of attack? (in hours)	Triggers?	Any symptoms before the headache?	Nausea? (Yes/No)	Any other symptoms?	Time away from normal activities? (in hours)	Medication taken: (list each, and say how many used each day)