

Headache log

Name:

Month:

Day	Day of Week	Time Circle	Duration	Severity Circle (1 is mild)	Nausea/Vomiting	Time off Work	Triggers Stress, period, etc.	Medications		
								Name	Times	Dose
Sample	Thursday	AM <input checked="" type="radio"/> PM	45 min	1 <input checked="" type="radio"/> 2 3	<input checked="" type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	Bright sunshine	Panadol	2pm	500 mg
1		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
2		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
3		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
4		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
5		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
6		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
7		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
8		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
9		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
10		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
11		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
12		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
13		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
14		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
15		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
16		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
17		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
18		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
19		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
20		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
21		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
22		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
23		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
24		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
25		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
26		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
27		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
28		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
29		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
30		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
31		AM PM		1 2 3	<input type="checkbox"/> N <input type="checkbox"/> V	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				

Written by HealthInfo clinical advisers. Last reviewed May 2021.