Name		Date of Birth	/ /

SECTION 1

Give details of all medications taken regularly for the headaches.

Name of medication	Dose of medication (give the total dose taken per day)	Date medication started or the dose altered	Date medication stopped

SECTION 2.

Give details of each headache in this section.

Date	Time of onset of headache	Duration of headache	Maximum severity of headache (score out of 10 where 0 is pain free and 10 is excruciating pain)	Medication taken to abort the headache (please also state the dose of the drug, if known)
/ /	am /pm	mins/hrs		
/ /	am /pm	mins/ hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		

/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		

Date	Time of onset of headache	Duration of headache	Maximum severity of headache (score out of 10 where 0 is pain free and 10 is excruciating pain)	Medication taken to abort the headache (please also state the dose of the drug, if known)
/ /	am /pm	mins/hrs		
/ /	am /pm	mins/ hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		

/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		
/ /	am/pm	mins/hrs		