DATE	Headache Duration		Headache severity				Associated Symptoms (please tick ✓)						Medications Used (Name and dose)	Relief (please tick ✓)			Triggers Activities/Foods School /Sleep / Stress video screens etc.
	More than 4 hours	Less than 4 hours	Stops & lies down	Decrease normal activity	Continue normal activities	Clear days	AP	N	V	PT	PN	WPA		No	Yes	Good	
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																	

Key: **AP**: **A**bdominal **P**ain **N**: **N**ausea **V: V**omiting **PT**: Sensitivity to light (**P**ho**t**ophobia)
PN: Sensitivity to sound (**P**ho**n**ophobia) **WPA**: **W**orsen with **P**hysical **A**ctivity

Instructions for completing your headache diary

Please complete diary for full calendar month. Each day please tick the box that indicates:

- how long (duration) your headache lasted for
- how it affected you (severity)
- associated symptoms other than the headache

If medicine was taken please record what it was and how much taken on that day.

Please tick the box to indicate if the medicine worked (relief).

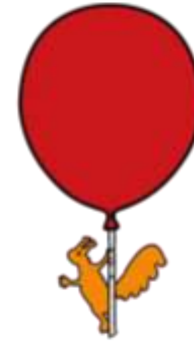
Please write anything you think may have caused the migraine (triggers).

Please record the:

Number of visits to your GP (doctor) for headache ....

Number of hospital visits for headache ....

Number of school days missed because of migraine ....



NHS
Alder Hey Children's
NHS Foundation Trust

My Monthly Headache Diary

Name ....

Month ....

Year ....