Headache Diary

Name Month Year

Headache Severity

The calendar is numbered 1-31 for each day of the month. On the days you have headache pain, record in the box the number that describes your headache pain: 1 = mild, 2 = moderate or 3 = severe.

Day of Month	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
Morning																															
Afternoon																															
Evening/Night																															

Day of Month	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
Disability for the day																															
Triggers																															
Menstrual Period																															

Disability Write a number from 0 to 3 that describes how your headaches pain affected your activities for the day:
0 = no effect, 1 = able to carry out your activities fairly well, 2 = you had difficulty with usual activities and cancelled less important ones
3 = you missed work for at least half the day, or stayed in bed for part of the day

Triggers Each trigger has been assigned a number. Record the numbers of the triggers you may have been exposed to on the day of headache.

Hormones
1. Menses
2. Ovulation
3. Hormone Replacement Therapy
4. Oral contraceptives

Diet
5. Alcohol
6. Chocolate
7. Aged Cheeses
8. Monosodium Glutamate (MSG)
9. Artificial sweeteners
10. Caffeine
11. Nuts
12. Nitrites, Nitrates
13. Citrus Fruits
14. Other

Changes
15. Weather
16. Seasons
17. Travel
18. Altitude
19. Schedule Changes
20. Sleeping Patterns (Too little/too much)
21. Diet
22. Skipping Meals

Sensory Stimuli
23. Strong Light
24. Flickering Lights
25. Odors

"Stress"
26. Let-Down Periods
27. Intense Activity
28. Loss (Death, Separation, Divorce)
29. Relationship Difficulties
30. Job Loss/Change
31. Crisis
32. Other

Menstrual Periods Place an "X" on the days you have your period.

Acute Medicines

On the days you take medicines to relieve your headache, write the names of the medicines and the doses. Check off each dose you take. Also, record in the appropriate box a number from 0 to 3 that describes the amount of overall relief you got from the medicine: 0 = no relief, 1 = slight relief, 2 = moderate relief, or 3 = complete relief.

Day of Month	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
Medicine: Dose:																															
Overall Relief																															
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Preventive Medicines

If your provider has prescribed preventive medicines, check off the day on the calendar every time your take a medicine.

Medicine: Dose:	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

MIDAS (migraine disability assessment)

The MIDAS (migraine disability assessment) questionnaire was put together to help you measure the impact your headaches have on your life over the last 3 months and to communicate this more effectively. The best way to this is by counting the numbers of days of your life which are affected by Headaches. You can do this for yourself as follows:

Please complete Questions about ALL your headaches you have had over the last month. Leave the box set to zero if you did not do the activity in the last three months.

For questions 1 and 2, **work or school** means paid work or education if you are a student at school or college. For Questions 3 and 4, **household work** means activities such as housework, home repairs and maintenance, shopping as well as caring for children and relatives.

INSTRUCTIONS • Please answers the following questions about ALL your headaches you have had over the last 3 months. Select your answer in the box next to each question. If a single headache affects more than one area of your life (e.g., work and family life) it is counted more than once. Select zero if you did not have the activity in the last 3 months.

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1. On how many days in the last 3 months did you miss work or school because your headaches? ____
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? ____
   (Do not include days you counted in question 1 where you missed work or school.)
3. On how many days in the last 3 months did you not do household work because of your headaches? ____
4. How many days in the last three months was your productivity in household work reduced by half of more because of your headaches? ____
   (Do not include days you counted in question 3 where you did not do household work.)
5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches? ____

Your Total Score: ____

What Your Physician will need to know about your headache:

A. On how many days in the last 3 months did you have a headache?
   (If a headache lasted more than 1 day, count each day.) ____
B. On a scale of 0 - 10, on average how painful were these headaches?
   (where 0 = no pain at all and 10 = pain as bad as it can be.) ____

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