Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

HEADACHE DIARY

Index to Health Diary\Encounter

Date: ______________________________

Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I had headaches lasting how long?																
Intensity (1-10)																
Missed work Y/N																
Aura (describe)																
Nausea Y/N																
Light sensitive Y/N																
Sound sensitive Y/N																
Medications*:																
Good response Y/N																

* Please chart all medications that you take as needed for a headache or other pain

Day	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
I had headaches lasting how long?															
Intensity (1-10)															
Missed work Y/N															
Aura (describe)															
Nausea Y/N															
Light sensitive Y/N															
Sound sensitive Y/N															
Medications*:															
Good response Y/N															

* Please chart all medications that you take as needed for a headache or other pain

Signature of Patient/Representative: ______________________________ Date: __________ Time: __________

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ______________________________ Relationship: ______________________________

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: ____________________

Reviewed by: ______________________________ Date: __________ Time: __________