Patient Name

DOB:

MR #

Month: ____________________

University of Wisconsin Hospital and Clinics
University of Wisconsin Medical Foundation

NEUROLOGY HEADACHE DIARY

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
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	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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: __________ AM PM

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: __________ AM PM