**My headache diary Name ……………………….**

**Please record all headaches not just the bad ones. Complete as fully as you can and bring this sheet to your follow up appointment**

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| --- | --- | --- | --- | --- | --- | --- |
| Date and time started | Date and time finished | Pain level (please use visual scale) | Where do you feel your headache? | Trigger or warning signs? | Medication usedHow many times? | Other symptoms at the time (e.g. vomiting) |
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