

TEXOMA NEUROLOGY ASSOCIATES, P.A.

Weekly Calendar for Headaches

Patient Number _____ Age _____

Sex: Male (1)
Female (2)

Week of: _____
(Month) (Day) (Year)

Sunday Headache? Yes (1) No (2) _____

If yes, answer the following questions 1 through 7.

- 1. How long to mild/none _____ hr _____
- 2. Maximum severity 1 2 3 4 5 6 7 8 9 10 _____
- 3. Nausea Yes (1) No (2) _____
- 4. Light/sound sensitivity Yes (1) No (2) _____
- 5. One-sided Yes (1) No (2) _____
- 6. Throbbing Yes (1) No (2) _____
- 7. Made worse by exertion? Yes (1) No (2) _____
- Migraine? Yes (1) No (2) _____

Monday Headache? Yes (1) No (2) _____

If yes, answer the following questions 1 thru 7.

- 1. How long to mild/none _____ hr _____
- 2. Maximum severity 1 2 3 4 5 6 7 8 9 10 _____
- 3. Nausea Yes (1) No (2) _____
- 4. Light/sound sensitivity Yes (1) No (2) _____
- 5. One-sided Yes (1) No (2) _____
- 6. Throbbing Yes (1) No (2) _____
- 7. Made worse by exertion? Yes (1) No (2) _____
- Migraine? Yes (1) No (2) _____

Tuesday Headache? Yes (1) No (2) _____

If yes, answer the following questions 1 thru 7.

- 1. How long to mild/none _____ hr _____
- 2. Maximum severity 1 2 3 4 5 6 7 8 9 10 _____
- 3. Nausea Yes (1) No (2) _____
- 4. Light/sound sensitivity Yes (1) No (2) _____
- 5. One-sided Yes (1) No (2) _____
- 6. Throbbing Yes (1) No (2) _____
- 7. Made worse by exertion? Yes (1) No (2) _____
- Migraine? Yes (1) No (2) _____

Patient number _____

TEXOMA NEUROLOGY ASSOCIATES, P.A.

Week of: _____
(Month) (Day) (Year)

Wednesday	Headache?	Yes (1)	No (2)	_____
If yes, answer the following questions 1 thru 7.				
1. How long to mild/none	_____ hr			_____
2. Maximum severity	1 2 3 4 5 6 7 8 9 10			_____
3. Nausea	Yes (1)	No (2)		_____
4. Light/sound sensitivity	Yes (1)	No (2)		_____
5. One-sided	Yes (1)	No (2)		_____
6. Throbbing	Yes (1)	No (2)		_____
7. Made worse by exertion?	Yes (1)	No (2)		_____
Migraine?	Yes (1)	No (2)		_____

Thursday	Headache?	Yes (1)	No (2)	_____
If yes, answer the following questions 1 thru 7.				
1. How long to mild/none	_____ hr			_____
2. Maximum severity	1 2 3 4 5 6 7 8 9 10			_____
3. Nausea	Yes (1)	No (2)		_____
4. Light/sound sensitivity	Yes (1)	No (2)		_____
5. One-sided	Yes (1)	No (2)		_____
6. Throbbing	Yes (1)	No (2)		_____
7. Made worse by exertion?	Yes (1)	No (2)		_____
Migraine?	Yes (1)	No (2)		_____

Friday	Headache?	Yes (1)	No (2)	_____
If yes, answer the following questions 1 thru 7.				
1. How long to mild/none	_____ hr			_____
2. Maximum severity	1 2 3 4 5 6 7 8 9 10			_____
3. Nausea	Yes (1)	No (2)		_____
4. Light/sound sensitivity	Yes (1)	No (2)		_____
5. One-sided	Yes (1)	No (2)		_____
6. Throbbing	Yes (1)	No (2)		_____
7. Made worse by exertion?	Yes (1)	No (2)		_____
Migraine?	Yes (1)	No (2)		_____

Patient number _____

TEXOMA NEUROLOGY ASSOCIATES, P.A.

Week of: _____
(Month) (Day) (Year)

Saturday	Headache?	Yes (1)	No (2)	_____
If yes, answer the following questions 1 thru 7.				
1. How long to mild/none	_____ hr			_____
2. Maximum severity	1 2 3 4 5 6 7 8 9 10			_____
3. Nausea	Yes (1)	No (2)		_____
4. Light/sound sensitivity	Yes (1)	No (2)		_____
5. One-sided	Yes (1)	No (2)		_____
6. Throbbing	Yes (1)	No (2)		_____
7. Made worse by exertion?	Yes (1)	No (2)		_____
Migraine?	Yes (1)	No (2)		_____

Weekly Score

No headache days _____

No migraine days _____

No headache hours _____

Mean severity _____