

**Semmes Murphey Clinic (Neurology)**  
**Headache Log**

**PATIENT NAME / ID#:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Month:** \_\_\_\_\_

Date	Did you have a headache (HA) today?	Duration of headache (# of hours HA lasted)	Medication taken to get rid of headache	Level of relief (none, mild, moderate, or complete)
1 <sup>st</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2 <sup>nd</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3 <sup>rd</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
8 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
9 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
10 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
11 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
12 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
13 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
14 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
15 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
16 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
17 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
18 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
19 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
20 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
21 <sup>st</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
22 <sup>nd</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
23 <sup>rd</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
24 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
25 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
26 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
27 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
28 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
29 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
30 <sup>th</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
31 <sup>st</sup>	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**\*PLEASE BRING THIS LOG TO YOUR NEXT APPOINTMENT\***