Peled Plastic Surgery

SAN FRANCISCO & WALNUT CREEK

PATIENT NAME: _____

DATE	HEADACHE (YES OR NO)	START TIME	END TIME	TOTAL TIME	INTENSITY (0-10) 0 = NO PAIN, 10= WORST PAIN	LOCATION: ABOVE EYEBROWS, TEMPLE(S), BACK OF NECK, OTHER	ASSOCIATED SYMPTOMS (i.e.. NAUSEA, VOMITING)	DID ANYTHING BRING ON OR MAKE YOUR HEADACHE WORSE (i.e. STRESS, BRIGHT LIGHTS)
Ex.	*Y*	*11 AM*	*3PM*	*4 hrs*	*8*	*Back of neck on right*	*Nausea, lightheaded*	*Chocolate, sunshine*

HEADACHE LOG

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