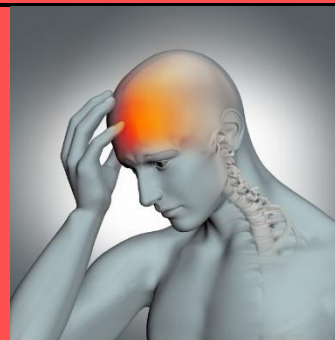


SUFFERING FROM RECURRENT/CHRONIC HEADACHES!!!



THINK AND NOTE DOWN THESE THINGS

Please note these details and visit your doctor; this will help your physician in treating your headache.

- **WHEN DID YOU EXPERIENCE YOUR FIRST HEADACHE?**
AGE/ SINCE PARTICULAR ILLNESS/ INJURY ETC.
- **WHAT CAUSES/ TRIGGERS HEADACHE PRESENTLY.**
ANY FOOD/ EMOTION/ STRESS/ LIGHT/ EXERCISE/ SMELL ETC
- WHAT IS THE **LOCATION** OF YOUR HEADACHE?
ONE/ BOTH SIDES, AROUND EYE, NECK ETC.
- WHAT IS THE **CHARACTER** OF HEADACHE?
Eg. PRESSING, BURNING, THROBBING ETC.
- HOW **SEVERE** IS THE HEADACHE ON A SCALE OF 1-10?
- HOW YOUR **HEADACHE AFFECTS YOUR WORK?**
- **HOW LONG IT LASTS?**
DURATION- MINUTES/ HOURS/ DAYS. WITH MEDICINE AND WITHOUT MEDICINE
- WHAT CAUSES **HEADACHE TO INCREASE** DURING ATTACK.
Eg. NOISE/ LIGHT ETC.
- WHAT CAUSES IT TO **BECOME BETTER** / WHAT DO YOU DO SO THAT THE HEADACHE COMES DOWN?
Eg. LYING DOWN/ ANY PARTICULAR POSITION/ ANY MEDICATION ETC.
- WHAT **OTHER PROBLEMS** DO YOU FACE DURING HEADACHE?
ANY OTHER SYMPTOMS WITH HEADACHE.
- BEFORE THE HEADCAHE STARTS DO YOU FEEL IT COMING; DO YOU FEEL SOME CHANGES OR **PREMONITORY SYMPTOMS** THAT WILL TELL YOU THAT HEADACHE IS GOING TO COME?
- HOW **FREQUENTLY** DO YOU GET HEADCAHE?
Eg. ANY PARTICULAR TIMER OF DAY/ WEEKLY, MONTHLY, ETC.
- DID ANYBODY IN THE **FAMILY** SUFFERE FROM SAME PROBLEM?