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?

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