Instructions: For each day please answer the "yes/no" questions. On headache days, please also answer whether you think this headache was a migraine.

A migraine is defined as pain in the head that includes at least 2 or more of the following features (1. throbbing; 2. pain in front, side, top, or back of head; 3. moderate or severe pain; 4. worsens with activity) **AND** 1 or more of the following 2 associated symptoms (1. nausea and/or vomiting; 2. light/sound sensitivity).

Form 5

The Migraine Discovery Pilot Study

Headache Diary

January 2017

Subject ID: _____

Visit Name:_____

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1 Headache* Y N Migraine* Y N	2 Headache* Y N Migraine* Y N	3 Headache* Y N Migraine* Y N	4 Headache* Y N Migraine* Y N	5 Headache* Y N Migraine* Y N	6 Headache* Y N Migraine* Y N	7 Headache* Y N Migraine* Y N
8 Headache* Y N Migraine* Y N	9 Headache* Y N Migraine* Y N	10 Headache* Y N Migraine* Y N	11 Headache* Y N Migraine* Y N	12 Headache* Y N Migraine* Y N	13 Headache* Y N Migraine* Y N	14 Headache* Y N Migraine* Y N
15 Headache* Y N Migraine* Y N	16 Headache* Y N Migraine* Y N	17 Headache* Y N Migraine* Y N	18 Headache* Y N Migraine* Y N	19 Headache* Y N Migraine* Y N	20 Headache* Y N Migraine* Y N	21 Headache* Y N Migraine* Y N
22 Headache* Y N Migraine* Y N	23 Headache* Y N Migraine* Y N	24 Headache* Y N Migraine* Y N	25 Headache* Y N Migraine* Y N	26 Headache* Y N Migraine* Y N	27 Headache* Y N Migraine* Y N	28 Headache* Y N Migraine* Y N
29 Headache* Y N Migraine* Y N	30 Headache* Y N Migraine* Y N	31 Headache* Y N Migraine* Y N				

***If you answered "YES" this is a headache day, please complete a headache record (Form 6) for the worst (most severe) headache that you had that day.**

Study Coordinators: When reviewing the calendars with subjects, be sure to verify the presence of a headache/migraine **EACH DAY** & check that Form 6 has been completed for **EACH** headache day.

Initial & date here when review complete: _____

FORM 6	Headache Record	Page 1 of 1
The Migraine Discovery Pilot Study Initials of Completer: ____ ____ ____	Subject ID: _____ Visit Name : _____	

1. Date of current headache (please check your headache calendar)
   ___ / ___ / _____ (mm/dd/yyyy)
2. What time did your headache start?
   ___:___ (record time) AM/PM (circle one) ☐ I woke up with this headache
3. What time did your headache end?
   ___:___ (record time) AM/PM (circle one) ☐ I went to bed with this headache
4. What pain medication(s) did you take for this headache? (select all that apply)
   ☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil, Motrin) ☐ Naproxen (Aleve)
   ☐ Aspirin ☐ Excedrin ☐ Amerge (Naratriptan)
   ☐ Axert (Almotriptan) ☐ Frova (Frovatriptan) ☐ Imitrex (Sumatriptan)
   ☐ Maxalt (Rizatriptan) ☐ Relpax (Eletriptan) ☐ Zomig (Zolmitriptan)
   ☐ Other _____
5. Which word describes the severity of your headache? (select only one)
   ○ Mild ○ Moderate ○ Severe
6. Rate your average pain for this headache on a scale of 0 - 10 ("0" = no pain & "10" = the worst pain). _____
7. Which of the following describes the pain you feel? (select all that apply)
   ☐ Throbbing ☐ Pressing / Squeezing ☐ Stabbing
   ☐ Constant ☐ Sharp ☐ Other (list): _____
8. What is the location of your headache pain? (select only one)
   ○ One side of your head ○ Both sides of your head
9. Which part(s) of your head hurts? (select all that apply)
   ☐ Both Temples / Sides ☐ Left Temple / Side ☐ Right Temple / Side
   ☐ Around Eyes ☐ Behind Eyes ☐ Top
   ☐ Front ☐ Back ☐ All Over
   ☐ Other (list): _____
10. Did you have any auras (warnings) that today's headache was going to start?
    ○ Yes ○ No
    a. If yes, which type of auras did you have today? (select all that apply)
       ☐ Visual ☐ Sensory ☐ Trouble Talking
       ☐ Weakness ☐ Smell ☐ Taste
       ☐ Auditory ☐ Other (list): _____
11. Do you have any of these symptoms? (select all that apply)
    ☐ Nausea ☐ Sensitivity to Smells ☐ No Symptoms
    ☐ Vomiting ☐ Lightheadedness ☐ Other (list):
    ☐ Sensitivity to Light ☐ Difficulty Thinking _____
    ☐ Sensitivity to Sound
12. Did today's headache change your activity level?
    ○ Yes ○ No
13. Does activity or play make today's headache worse?
    ○ Yes ○ No
14. Was today a school day? ○ Yes ○ No
    a. If yes, select one:
    ○ I missed a full day of school.
    ○ I missed a half or part of the day of school.
    ○ I attended a full day of school, my headache affected my performance.
    ○ I attended a full day of school, my headache did not affect my performance.
15. Could you do things at home (chores, homework, etc)? ○ Yes ○ No
    a. If yes, select one:
    ○ My headache affected my performance.
    ○ My headache did not affect my performance.
16. Did you participate in other activities (play sports, go out, play)? ○ Yes ○ No
    a. If yes, select one:
    ○ My headache affected my performance.
    ○ My headache did not affect my performance.

This study used the standards set by the National Institute of Neurological Disorders and Stroke Common Data Elements (CDE) Project for the Headache Diary and Headache Record to collect participant's demographic, headache diary and headache record data. Additional information on these Common Data Elements is available at https://www.commondataelements.ninds.nih.gov/ProjReview