# Mein Kopfschmerzkalender

## Monat/Jahr: _____

## Name/Vorname:

_____

**Beginn der Kopfschmerz-Symptome:**

_____

**Wie stark waren die Schmerzen?**

Leicht (1-3)
Mittel (4-5)
Stark (6-8)
sehr stark (9-10)

**Welche Medikamente haben Sie gegen den Schmerz genommen?**

A ASS _____ mg
Ib Ibuprofen _____ mg
Pa Paracetamol _____ mg
Sm Sumatripan _____ mg

_____ mg

_____ mg

**Auslöser/Trigger**

A Aufregung/Stress
E Entspannung/Erholung
S Schlafprobleme
M Menstruation/Regel

_____

_____

Praxisgemeinschaft
für Kinder & Jugendmedizin
Dr. Hassemer
& Dr. Schock

Öfnungszeiten
Mo,Di,Do: 8:30-12:00
14:30-17:00
Mi + Fr: 8:30-12:00
Telefon:06101-83078

| | Wann? Wie stark? Wie lang? | | | Schmerzform und auf welcher Seite? | | | | | Begleiterscheinungen | | | | | | * rückseitig beschreiben | | Anzahl d. Eingenommenen Medikamente | | | Wie war die Wirkung? | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tag | Stärke 0-10 | Beginn/Uhrzeit | Dauer (Std.) | pulsierend/pochend | dumpf/drückend | stechend/bohrend | einseitig (re/li) | beidseitig | Übelkeit (Stärke 0-10) | Erbrechen (0-10) | lichtempfindlich (0-10) | lärmempfindlich (0-10) | Sehstörungen * | Sonstiges * | Vermutlicher Auslöser/Trigger | Medikamente (Dosierung) | Tropfen | Tabletten | Zäpfchen | gut (g) | wenig (w) | gar keine (k) |
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