[To be printed on pink card]

The impact of AZD4017 on Intracranial pressure and Symptoms of Idiopathic Intracranial Hypertension

IIH:DT Headache Diary

Patient's Name _____

Patient's Study Number _____

Date and Visit _____

Contact: Monday–Friday <<insert local contact hours and telephone number>>

Any other time - **Emergency contact**
<<insert local switchboard>> (Switchboard)
Please ask for the Neurology on-call doctor

PLEASE BRING THIS DIARY WITH YOU TO THE VISITS INDICATED ON YOUR APPOINTMENT DIARY (YELLOW CARD).

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Please record EVERY DAY:

The **severity** of your headache from 0 (no headache) to 10 (worst pain ever experienced)

The **total duration** of your headaches in hours (**e.g.** 4 hours)

The **number** and **type** of **pain killers taken**.

If you have **not** taken any painkillers, please write **'none'** in the painkillers section.

DAY	**DATE** DD-MMM-YYYY	**SEVERITY** (0-10)	**DURATION** (hours)	**PAINKILLERS** (Type and Number)
1			_____hours	_____ _____
2			_____hours	_____ _____
3			_____hours	_____ _____
4			_____hours	_____ _____
5			_____hours	_____ _____
6			_____hours	_____ _____
7			_____hours	_____ _____