Cycle # _____

Chemotherapy Side Effects Worksheet

Medicines or drugs that destroy cancer cells are called cancer chemotherapy (chemo). Chemotherapy differs from surgery or radiation in that it treats the whole body. Usually chemotherapy is combined with other forms of therapy, like surgery, radiation, or biologic therapies.

Like all cancer therapies, chemotherapy drugs have side effects, some of which can be serious. It is important to keep track of any side effects you are having so your cancer care team can help you manage these. This worksheet will help you do that.

Listed on the following pages are the most common side effects experienced by patients receiving chemotherapy.

- You may have none, some, or all of these, or you may have side effects not listed here.
- With each side effect listed, there are suggestions on how to describe them to your doctor.
- Some side effects are more serious than others.
- **Ask your doctor which side effects he or she needs to know about right away.** Record these on the last page.

Print a new worksheet for each week that you are receiving treatment and take the worksheet with you when you visit the doctor.

How to Use This Worksheet

- This worksheet covers 7 days of a chemotherapy cycle. You will need to print additional worksheets for each week of your cycle.
- Fill in the days of the cycle of therapy (for example, the day you start therapy is Day 1) and the dates for the week.
- For each day of the cycle, go down the column for that day and check the appropriate box describing the severity of each side effect. If you do not have a particular side effect, check the "None" box.
- Write down what medications you took to treat the side effect, if any.
- **If you have a side effect that can be described as "severe", notify your doctor right away.**

Be sure to talk to your cancer care team about which side effects are most common with your chemo, how long they might last, how bad they might be, and when you should call the doctor's office about them.

Chemotherapy Side Effects Worksheet

Cycle # ___________

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Day of Chemotherapy Cycle	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**
Fever/Chills: Write down your highest temperature for the day. None – Temperature 98.6° F Mild – Fever 98.6° F to 100.4° F Moderate – Fever 100.4° F to 104° F* Severe – Fever greater than 104° F*	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe	Max Temp: ________°F ☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Fatigue (Feeling Weak): None Mild – Able to do normal activities with some effort Moderate – In bed less than half of the day Severe – In bed more than half the day*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Nausea: None Mild – Can eat Moderate – Eating/drinking less than normal Severe – Can't eat or drink*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Vomiting: None Mild – Vomited once during the day Moderate – Vomited 2 to 5 times during the day* Severe – Vomited 6 or more times during the day*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Sore Mouth: None Mild – Soreness or painless ulcer Moderate – Soreness or painful ulcer but can eat* Severe – Painful ulcer and cannot eat*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
***Let your doctor know about this right away.**							

Chemotherapy Side Effects Worksheet

Cycle # ___________

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Day of Chemotherapy Cycle	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**	**Day _____**
Diarrhea: Write down number of bowel movements per day. None Mild – Loose stools Moderate – Watery stools, many more than normal Severe – Constant or bloody, or causing you to feel dizzy*	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: ________ ☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Constipation: None Mild – No bowel movement for 2 days Moderate – No bowel movement for 3 to 4 days* Severe – No bowel movement for more than 4 days or swollen abdomen*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Loss of Appetite (Anorexia): None Mild – Slightly decreased appetite Moderate – Usually not hungry Severe – Nothing looks good/unable to eat*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Pain or difficulty with swallowing: None Mild – Pain but can eat Moderate – Pain requiring soft or liquid diet* Severe – Unable to eat at all*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
***Let your doctor know about this right away.**							

Chemotherapy Side Effects Worksheet

Cycle # _____

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Day of Chemotherapy Cycle	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**
Swelling (Edema) in Hands or Feet: None Mild – Swelling in hands or feet Moderate – Swelling extending up arm or leg* Severe – Swelling with pain or trouble breathing*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Allergic Reaction: None Mild – Rash, No fever Moderate – Rash, fever <100.4F* Severe – Hives, fever >100.4F* Difficulty breathing. Seek immediate treatment*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Itching or Rash: None Mild – Scattered skin rash with redness/mild itching* Moderate – Generalized rash with sores* Severe – Rash with open sores*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Shortness of Breath: None Mild – With exertion Moderate – With normal level of activity* Severe – At rest*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
***Let your doctor know about this right away.**							

Chemotherapy Side Effects Worksheet

Cycle # _____

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Day of Chemotherapy Cycle	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**	**Day ____**
Muscle or Joint Pain: None Mild – Sore but does not require medicine Moderate – Requires medicine for pain Severe – Pain medicine does not help*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
Numbness or Tingling in Hands or Feet: None Mild – Tingling sensation Moderate – Tingling, some numbness Severe – Numbness interfering with function (for example, can't hold a coffee cup)*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medicines taken for this here —>							
LIST ANY OTHER SIDE EFFECTS YOU EXPERIENCE IN THE BOXES BELOW (Some other side effects include: hair loss, memory or concentration problems, easy bruising or bleeding, skin or nail changes like dry skin or color changes, urine or bladder problems)							
Side Effect:	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Medications taken —>							
Side Effect:	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Medications taken —>							
***Let your doctor know about this right away.**							

Chemotherapy Side Effects Worksheet

Cycle # _____

Questions to Ask My Doctor

Which side effects should I notify you about right away?

What Should I Do for the Side Effects That I Have?

Notes

For More Information…
We're available to answer your questions about cancer. Contact us at 1-800-227-2345, or visit us online at www.cancer.org.

External Radiation Side Effects Worksheet

External radiation therapy uses special equipment to deliver high doses of radiation to cancerous tumors, killing or damaging them so they cannot grow, multiply, or spread. Unlike chemotherapy, which exposes the entire body to cancer-fighting chemicals, radiation therapy affects only the tumor and the surrounding area.

On the following pages are the most common side effects experienced by patients receiving external radiation therapy.

- You may have none, some, or all of these, or you may have side effects not listed here.
- With each side effect listed below there are suggestions on how to describe them to your doctor.
- Some side effects are more serious than others.
- **Ask your doctor which side effects he or she needs to know about immediately.** Record these on the last page.

How to Use This Worksheet

- This worksheet will cover 6 weeks of radiation therapy. Fill in the date for the start of each week. For example, the week you start therapy is Week #1. If your therapy lasts beyond 6 weeks, you will need to print an additional worksheet.
- Side effects are listed in the left column.
- For each week, go down the column for that week and check the appropriate box describing the severity of each side effect. If you do not have a particular side effect, check the "None" box.
- Take this worksheet with you to your doctor visits.
- **If you have a side effect that can be described as "severe", notify your doctor right away.**
- At the end of the list, we have left spaces for you to add any side effects you may have that are not listed here. Use the same format to describe the severity of the symptom and any medications you took to treat it.

***Remember, your doctor may want to know immediately if you have some of these side effects.**
For more information on Radiation Therapy go to www.cancer.org.

External Radiation Side Effects Worksheet

Date	/ /	/ /	/ /	/ /	/ /	/ /
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
General Symptoms						
Fatigue: None Mild – Normal activity with effort Moderate – In bed less than half of day Severe – In bed more than of day*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Skin Irritation (in areas where radiation therapy is given): None Mild – Faint redness and scaling Moderate – Redness or moist peeling especially at skin folds* Severe – Swelling and moist peeling in large area or ulcer in skin*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Fever/Chills: Write down your highest temperature for the week. None – Temperature 98.6° F Mild – Fever 98.6° F to 100.4° F Moderate – Fever 100.4° F to 104° F* Severe – Fever greater than 104° F*	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe	_____° F ☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken for this here —>						
If You Are Receiving Radiation to the Head or Neck Area:						
Sore Mouth: None Mild – Soreness, with no ulcers Moderate – Soreness or painful ulcer/able to eat* Severe – Painful ulcer and cannot eat or toothache*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken here —>						
Dry mouth (Xerostomia): Decreased saliva Thick saliva No saliva	☐ Decreased ☐ Thick ☐ No Saliva	☐ Decreased ☐ Thick ☐ No Saliva	☐ Decreased ☐ Thick ☐ No Saliva	☐ Decreased ☐ Thick ☐ No Saliva	☐ Decreased ☐ Thick ☐ No Saliva	☐ Decreased ☐ Thick ☐ No Saliva
***Let your doctor know about this right away**						

External Radiation Side Effects Worksheet

Date	/ /	/ /	/ /	/ /	/ /	/ /
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
If You Are Receiving Radiation to the Abdomen:						
Nausea: None Mild – Able to eat Moderate – Eating/drinking less than normal Severe – Can't eat or drink*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken here —>						
Vomiting: None Mild – Vomiting once Moderate – Vomiting 2 to 5 times in a day* Severe – Vomiting 6 or more times a day*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken here —>						
Diarrhea (Write down highest number of bowel movements in a day): None Mild – 2 to 3 stools per day over normal Moderate – 4 to 6 stools per day over normal* Severe – Watery stools or 7 to 9 stool*	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe	# of BMs: _____ ☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken here —>						
Change in Appetite: Reduced food and fluid intake Call doctor if you are unable to eat or drink*	☐ No change ☐ Decreased ☐ Unable to eat or drink	☐ No change ☐ Decreased ☐ Unable to eat or drink	☐ No change ☐ Decreased ☐ Unable to eat or drink	☐ No change ☐ Decreased ☐ Unable to eat or drink	☐ No change ☐ Decreased ☐ Unable to eat or drink	☐ No change ☐ Decreased ☐ Unable to eat or drink
Note any changes here —>						

***Let your doctor know about this right away**

External Radiation Side Effects Worksheet

Date	/ /	/ /	/ /	/ /	/ /	/ /
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
If You Are Receiving Radiation to the Chest:						
Pain or difficulty with swallowing: None Mild – Pain but can eat Moderate – Pain requiring soft or liquid diet* Severe – Unable to eat at all*	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Write any medications taken here —>						
Soreness of the breast:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If You Are Receiving Radiation to the Pelvis (Females):						
Notify your doctor if you have any vaginal discharge or dryness* Note any symptoms here —> Write any medications taken here —>						
If You Are Receiving Radiation to the Brain:						
Notify your doctor if you have any of the following: Headache* Seizure* Nausea/vomiting* Decreased hearing/loss* Note any symptoms here —>						
***Let your doctor know about this right away**						

External Radiation Side Effects Worksheet

Date	/ /	/ /	/ /	/ /	/ /	/ /
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**
LIST ANY OTHER SIDE EFFECTS YOU EXPERIENCE IN THE BOXES BELOW						
Side Effect:	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Side Effect:	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe
Side Effect:	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ None ☐ Mild ☐ Moderate ☐ Severe

External Radiation Side Effects Worksheet

Questions to Ask My Doctor

Which side effects should I notify you about right away?

What Should I Do for the Side Effects That I Have?

Notes

For More Information…
We're available to answer your questions about cancer. Contact us at 1-800-227-2345, or visit us online at www.cancer.org.

Daily Pain Diary

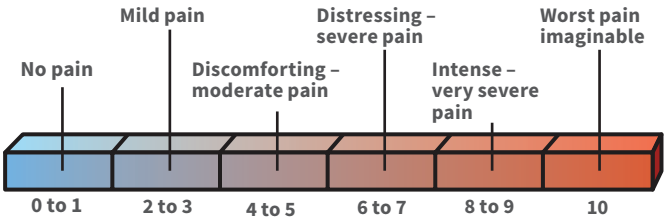
Many people with cancer have pain from cancer, cancer treatment, or some other cause. Having pain is *not* a normal part of cancer and cancer treatment. Nearly all cancer pain can be controlled or relieved. Good pain management is part of good cancer care.

Only you know how much pain you have. Your cancer care team and loved ones have no way of knowing about your pain unless you tell them. It helps to use words that clearly describe your pain. Tell your team:

- **Where you feel pain –** be specific, for instance: "the lower left side of my back"
- **What it feels like** – some words to use are:
  - Sharp **–** like a bad cut
  - Dull **–** like a sore muscle/muscle ache
  - Throbbing **–** like a headache
  - Steady **–** like a toothache or sore throat
  - Burning – like a bad sunburn
- **How severe the pain is** – Use the 0-to-10 pain scale tool described at right.
- **How long the pain lasts** – for example, minutes, hours, days
- **What eases the pain** – for instance, cold compresses, heat, repositioning, medicines
- **What makes the pain worse** – for example, moving, changing positions, it gets worse in the evening, etc.
- **What pain medicines you are taking,** when you take them, and how much relief you get from them

Tools for rating your pain

Using a pain scale helps to describe how much pain you have. For instance, try to put a number from 0 to 10 to your pain level. If you have no pain, use a 0. As the numbers get higher, they mean worse pain. A 10 means it is the worst pain you've ever had. You might say "My pain is a 7 on a 0-to-10 scale" or "a 2 on a 0-to-10 scale."



You can use this 0-10 rating scale to describe:

- How bad your pain is at its worst
- How bad your pain is most of the time
- How bad your pain is at its least

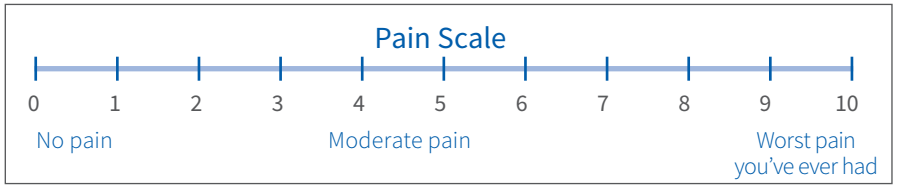
It can be hard to remember the details every time you have pain. The diary on the back of this sheet will help you keep track of your pain so you can tell your doctor or nurse exactly how you've been feeling. This will help your cancer care team understand your pain better.

Use this diary to record your pain and what you did to ease it each day. Fill in the chart, and take it with you to your next appointment. In the notes column you may want to write how you felt after taking the medicine, (for example, better able to sleep, eat, be active) and/or side effects causing problems (such as constipation, drowsiness, confusion).

If your pain is not relieved, tell your doctor or nurse. There are many ways to treat cancer pain. Work with your team to find the treatments that work best for you.

Daily Pain Diary

Date & time	Pain score (0 to 10)	Where pain is and how it feels (ache, sharp, throbbing, shooting, tingling, etc.)	What I was doing when it started	Name and amount of medicine, and time it was taken	Non-drug techniques I tried	How long the pain lasted	Pain score 1 hour after taking the medicine	Other notes



American Cancer Society®

cancer.org | 1.800.227.2345

WRITTEN AUGUST 2016

My Medicines Form

Use this form to record your medicines.

Date	Medicine	Purpose for medicine	Name and phone number of doctor who prescribed	Dose	When to take	**Notes** (Remember: if a medication is discontinued, record the stop date)

Appointments/Questions to Ask Form

Use this form to record your appointments and questions you would like to ask your health care provider.

Date	Time	Appointment with	Reason for appointment	Phone	Notes/Questions

Questions to Ask My Doctor About My Cancer

Being told you have cancer can be scary and stressful. You probably have a lot of questions and concerns. Learning about the disease, how it's treated, and how this information might apply to you is a lot to do on your own .You might need some help. Your American Cancer Society can give you general information about the cancer and its treatment, but your doctor is the best source of information about your situation.

It's important for you to be able to talk frankly and openly with your cancer care team. They want to answer all of your questions, no matter how minor they might seem to you. But it helps if you know what to ask. Here are some questions you can use to help you better understand your cancer and your options. Don't be afraid to take notes and tell the doctors or nurses when you don't understand what they're saying.

The questions are grouped by where you are in the process of cancer treatment. Not all of these questions will apply to you, but they should help get you started.

For more information on the type of cancer you have please contact your American Cancer Society toll free at 1-800-227-2345 or online at www.cancer.org.

When you're told you have cancer

1. Exactly what kind of cancer do I have?

2. How do I get a copy of my pathology report?

3. Where is the cancer located?

4. Has the cancer spread beyond where it started?

5. What’s the cancer’s stage? What does that mean?

6. How does this affect my treatment options and long-term outcome (prognosis)?

7. What are my chances of survival, based on my cancer as you see it?

8. How much experience do you have treating this type of cancer?

9. Will I need other tests before we can decide on treatment?

10. What are my treatment choices?

11. What treatment do you recommend and why?

12. What’s the goal of my treatment?

13. Should I think about genetic testing?

14. Should I get a second opinion? How do I do that?

15. Should I think about taking part in a clinical trial?

Questions to Ask My Doctor About My Cancer

When deciding on a treatment plan

1. What are the chances the cancer will come back after this treatment?

2. What would we do if the treatment doesn’t work or if the cancer comes back?

3. Will I be able to have children after treatment?

4. How much will I have to pay for treatment? Will my insurance cover any of it?

5. How long will treatment last? What will it involve?

6. Where will treatment be done?

7. What risks and side effects should I expect?

8. What can I do to reduce the side effects of the treatment?

9. How will treatment affect my daily activities?

10. Will I be able to work during treatment?

11. Will I lose my hair? If so, what can I do about it?

12. Will the treatment hurt? Will I have any scars?

Questions to Ask My Doctor About My Cancer

Before treatment

1. What should I do to get ready for treatment?

2. Will I need blood transfusions?

3. Should I change what I eat or make other lifestyle changes?

Questions to Ask My Doctor About My Cancer

During treatment

Once you have decided on treatment, you'll need to know what to expect and what to look for. All of these questions may not apply to you, but asking the ones that do may be helpful.

1. How will we know if the treatment is working?

2. Is there anything I can do to help manage side effects?

3. What symptoms or side effects should I tell you about right away?

4. How can I reach you on nights, holidays, or weekends?

5. Do I need to change what I eat during treatment?

6. Are there any limits on what I can do?

7. What kind of exercise should I do, and how often?

8. Can you suggest a mental health professional I can see if I start to feel overwhelmed, depressed, or distressed?

9. Will I need special tests, such as imaging scans or blood tests, and how often?

Questions to Ask My Doctor About My Cancer

After treatment

1. Do I need a special diet after treatment?

2. Are there any limits on what I can do?

3. What kind of exercise should I do now?

4. What type of follow-up will I need after treatment?

5. How often will I need to have follow-up exams and imaging tests?

6. What blood tests will I need?

7. How will I know if the cancer has come back? What should I watch for?

8. What are my options if the cancer comes back?

Questions to Ask My Doctor About My Cancer

Other questions I need answered

Along with the sample questions you've been given, be sure to ask any others you might have. For instance, you might need to know more about how long it will take to recover from surgery so you can plan your work schedule. Or, you may need to ask about insurance coverage or how you can get help paying for treatment. Write your own questions here.

Last Medical Review: 4/17/2013
Last Revised: 4/17/2013

Test Results Form

Use this form to record your medical test results.

Date	White Blood Cell Count (WBC)	Hemoglobin (HGB)	Platelets (PLT)	Other	Notes/Questions