

## 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 _____
<b>Fever/Chills:</b> 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 <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Max Temp: _____°F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Fatigue (Feeling Weak):</b> 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*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Nausea:</b> None Mild – Can eat Moderate – Eating/drinking less than normal Severe – Can't eat or drink*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Vomiting:</b> 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*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Sore Mouth:</b> None Mild – Soreness or painless ulcer Moderate – Soreness or painful ulcer but can eat* Severe – Painful ulcer and cannot eat*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> 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 ____
<b>Diarrhea:</b> 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: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Constipation:</b> 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*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Loss of Appetite (Anorexia):</b> None Mild – Slightly decreased appetite Moderate – Usually not hungry Severe – Nothing looks good/unable to eat*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Pain or difficulty with swallowing:</b> None Mild – Pain but can eat Moderate – Pain requiring soft or liquid diet* Severe – Unable to eat at all*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> 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 ____
<b>Swelling (Edema) in Hands or Feet:</b> None Mild – Swelling in hands or feet Moderate – Swelling extending up arm or leg* Severe – Swelling with pain or trouble breathing*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Allergic Reaction:</b> None Mild – Rash, No fever Moderate – Rash, fever <100.4F* Severe – Hives, fever >100.4F* Difficulty breathing. Seek immediate treatment*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Itching or Rash:</b> None Mild – Scattered skin rash with redness/mild itching* Moderate – Generalized rash with sores* Severe – Rash with open sores*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Shortness of Breath:</b> None Mild – With exertion Moderate – With normal level of activity* Severe – At rest*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>*Let your doctor know about this right away.</b>							



# Chemotherapy Side Effects Worksheet

Cycle # \_\_\_\_\_

Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Day of Chemotherapy Cycle	Day ____	Day ____	Day ____	Day ____	Day ____	Day ____	Day ____
<b>Muscle or Joint Pain:</b> None Mild – Sore but does not require medicine Moderate – Requires medicine for pain Severe – Pain medicine does not help*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>Numbness or Tingling in Hands or Feet:</b> None Mild – Tingling sensation Moderate – Tingling, some numbness Severe – Numbness interfering with function (for example, can't hold a coffee cup)*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>							
<b>LIST ANY OTHER SIDE EFFECTS YOU EXPERIENCE IN THE BOXES BELOW</b> (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)							
<b>Side Effect:</b>	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Medications taken —>							
<b>Side Effect:</b>	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Medications taken —>							
<b>*Let your doctor know about this right away.</b>							



# 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](http://www.cancer.org).