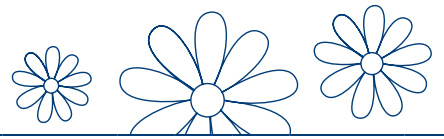
Toxicity Record



PRINT NAME:

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
DATE																												
DIARREAH: 1=2-3 stools over normal 2=4-6/day over normal 3=watery stools, 7-9/day 4=bloody stools, > 10/day																												
CONSTIPATION: 1=No BM x 2 days 2=No BM x 2-4 days 3=No BM > 4 days																												
RED/BURNING/WATERY EYES: 1=No BM x 2 days 2=No BM x 2-4 days 3=No BM > 4 days																												
SORE FINGERS/TOES: 1=red or mild pain 2=redness with pain 3=pain; interferes w/ daily activities																												
NUMBNESS/TINGLING: 1=mild 2=moderate 3=severe; interferes w/ daily activities																												
MUSCLE ACHE/PAIN: 1=mild 2=moderate 3=severe; interferes w/ daily activities																												
SKIN RASH: 1=scattered rash/redness 2=scattered rash w/itch+symptoms 3=generalized rash w/sores+symptoms 4=rash w/open sores+symptoms																												
TEMPERATURE: 1=98.7-100.4 2=100.5-104 CALL THE OFFICE 3=>104 CALL THE OFFICE																												

PRINT NAME:

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
FATIQUE: 1=Normal activity with effort 2=In bed < 50% of day 3=limited self care, in bed >50% of day																												
NAUSEA: 1=mild, able to maintain diet 2=moderate; decreased intake 3=severe; can't eat																												
VOMITING: 1=only once 2=2-5 times in one day 3= > 6 times 4= > 10 times																												
SORE MOUTH: 1 = soreness or painless ulcers 2=painful ulcers – able to eat 3=painful ulcers – cannot eat 4=required IV support																												
OTHER:																												

MEDICATIONS TAKEN (specify what you took it for, when you took it and how often):

We are interested in knowing about any side effects or symptoms which occur during and after your treatment. Please indicate on this sheet the symptoms you had by entering the number that best describes the severity. Also record the dates on which the symptoms occurred. Please bring this form with you when you return to the clinic and show it to your doctor or nurse. Additional sheet will be provided as necessary.

If you are rating symptoms at a 2 for more than 2 days call the office or if your symptoms are at 3 or greater