

Use the boxes below to jot down notes for yourself about medications, pain levels, and location of pain.

Medications:

Cycle #:

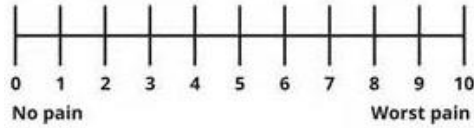
Notes:

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- _____

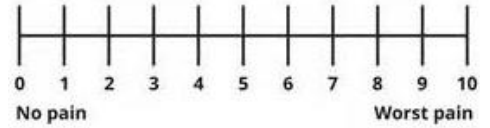
DATE:

Rate your pain:



DATE:

Rate your pain:

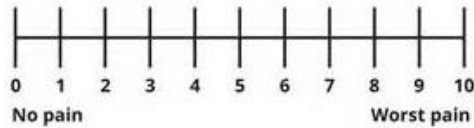


Notes:

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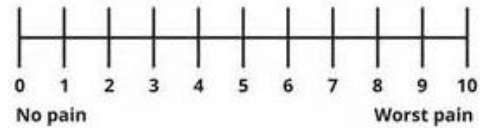
DATE:

Rate your pain:



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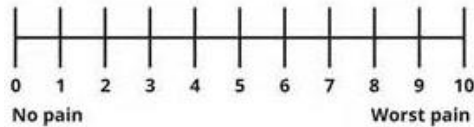


Notes:

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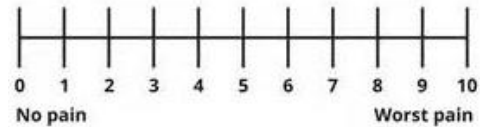
DATE:

Rate your pain:



DATE:

Rate your pain:

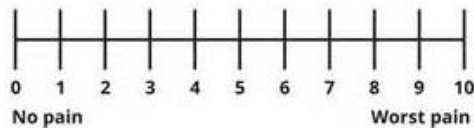


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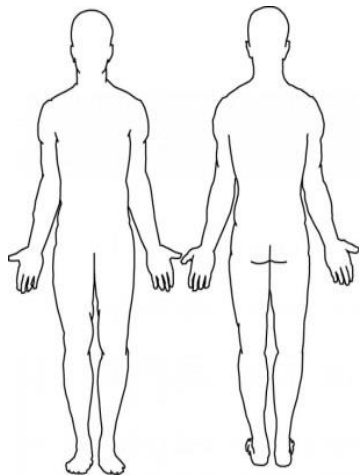


Notes:

- | Chemo Symptoms | Radiation Symptoms |
|-------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Sore Mouth | <input type="checkbox"/> Dizziness/disorientation |
| | <input type="checkbox"/> Weakness/fatigue |
| | <input type="checkbox"/> Hair loss |
| | <input type="checkbox"/> Poor wound healing |
| | <input type="checkbox"/> Low blood pressure |

DATE:

Mark the areas in pain:

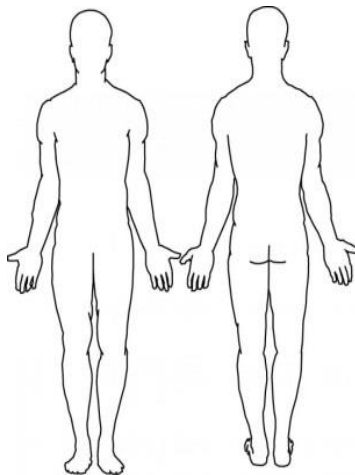


What does the pain feel like?

- Stabbing
- Throbbing
- Shooting
- Burning
- Radiating
- Dull
- Sharp
- Continuous
- In intervals
- Recurrent
- Chronic

DATE:

Mark the areas in pain:

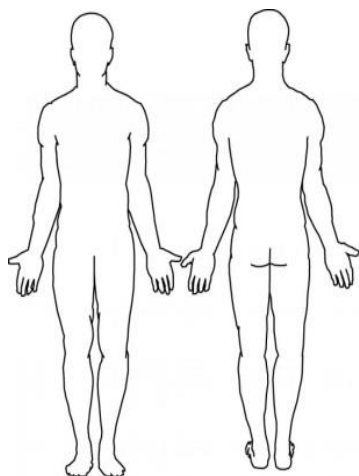


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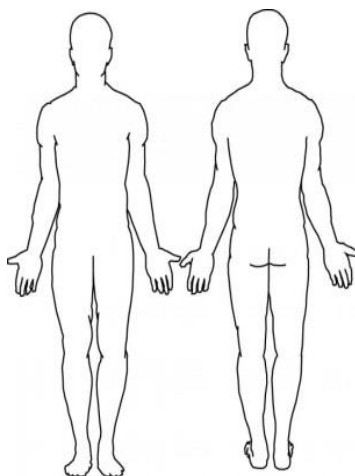


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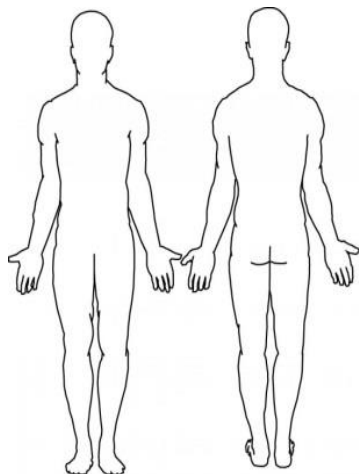


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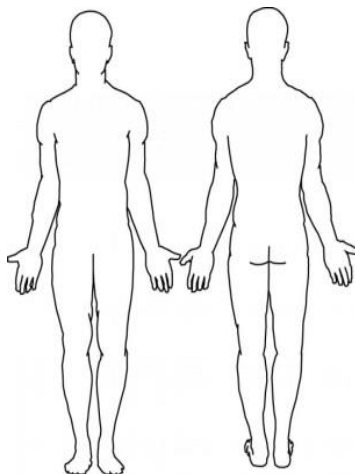


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