### SAMPLE PATIENT TOXICITY RECORD

Reviewing symptoms on a daily basis and taking a complete look at the patient’s charted toxicities at clinic visits allows the clinician to gain a better understanding of the symptoms and their severity, to make more informed decisions about continuation of therapy.

**Toxicity Record**

<table>
<thead>
<tr>
<th>NAME: ___________________________</th>
<th>COURSE #: ____________________</th>
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<tbody>
<tr>
<td>PT #: ____________________</td>
<td>Nurse: __________________, RN, BSN</td>
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We are interested in knowing about any side effects or symptoms that occur during and after your drug therapy. Please indicate on this sheet the symptom you had by entering the code number (#) that best describes the severity. Also, record the dates on which the symptoms occurred. Use the back of this sheet for comments. Please bring this form with you when you return to clinic and show it to your doctor and nurse. Additional sheets will be provided as necessary. Thank you for your cooperation.

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<th>DAYS</th>
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<tr>
<td>SYMPTOMS</td>
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<tr>
<td>HAIR THINNING/HAIR LOSS</td>
<td>0=mild hair loss</td>
<td>1=pronounced or total hair loss</td>
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<tr>
<td>FEVER</td>
<td>0=None</td>
<td>1=105.4-102.2°F</td>
<td>2=102.3-104°F</td>
<td>3=104°F&lt;24 h</td>
<td>4=104°F&gt;24 h</td>
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<tr>
<td>INFECTION</td>
<td>0=None</td>
<td>If present, describe</td>
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<tr>
<td>SORE MOUTH</td>
<td>0=None</td>
<td>1=painful ulcers, requires IV fluids</td>
<td>2=painful ulcers, requires IV nutrition or feeding tube</td>
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<td>COUGH</td>
<td>0=None</td>
<td>1=mild (relieved with over-the-counter medication)</td>
<td>2=moderate (requires narcotic)</td>
<td>3=severe cough or spasms poorly controlled or unresponsive to treatment</td>
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<td>VOMITING</td>
<td>0=None</td>
<td>1=1 episode in 24 h</td>
<td>2=2-5 episodes in 24 h</td>
<td>3=6 episodes in 24 h or requires IV fluids</td>
<td>4=requires intensive supportive care</td>
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<td>NAUSEA</td>
<td>0=None</td>
<td>1=able to eat</td>
<td>2=intake decreased</td>
<td>3=no intake, requires IV</td>
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<td>DIARRHEA</td>
<td>0=None</td>
<td>1=1 to 3 stools over normal</td>
<td>2=4 to 6/day over normal</td>
<td>3=watery stools, ≥7/day or requires IV fluids</td>
<td>4=requires intensive supportive care</td>
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<td>CONSTIPATION</td>
<td>0=None</td>
<td>1=requires stool softener or diet modification</td>
<td>2=requires laxatives</td>
<td>3=requires enema</td>
<td>4=obstruction</td>
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### Fatigue
0 = none  
1 = mild, normal activity with effort  
2 = moderate, difficulty performing some activities  
3 = severe, unable to perform some activities  
4 = bedridden or disabling

### Muscle Ache/Pain
0 = none  
1 = mild, not interfering with function  
2 = moderate, interferes with function but does not interfere with daily activities  
3 = severe, interferes with daily activities  
4 = disabling

### Headache
0 = none  
1 = mild  
2 = moderate  
3 = severe  
4 = disabling

### Numbness/Tingling
0 = none  
1 = mild, not interfering with function  
2 = moderate, interferes with function, but does not interfere with daily activities  
3 = severe, interferes with daily activities  
4 = permanent, interferes with function

### Edema
0 = none  
1 = not requiring therapy  
2 = symptomatic, requiring therapy  
3 = symptomatic, limiting function

### Skin Rash
0 = none  
1 = rash or redness, no itch  
2 = rash with itch or symptoms, ≤ 50% of body  
3 = rash or sores & symptoms, ≥ 50% of body  
4 = generalized rash with open sores and symptoms

### Injection Site Reaction
0 = none  
1 = pain, itching or redness  
2 = inflamed, swollen and painful  
3 = severe pain, ulceration

### Dyspepsia (Heartburn)
0 = none  
1 = mild  
2 = moderate  
3 = severe

### Anxiety or Depression
0 = none  
1 = mild  
2 = moderate  
3 = severe

### Drug/Medication
(include all non-prescription medications as well)