Side Effects Journal

Cycle No. ____________________

	Sunday	Monday	Tuesday
Date:	___/___/___	___/___/___	___/___/___
Medication I have taken today. [Including: over-the-counter, prescription, herbal, and/or vitamins] (Please specify)			
Feelings (mood) [0 -5] (where 0 is very sad and 5 is cheerful) Thoughts: Self-harm = SH Suicidal ideas = Su Activity Levels [0 - 5] (where 5 is pre-treatment level)			
Food: Breakfast = B Lunch =L Supper/Dinner = SD Snacks = SK(s) Drinks: Water = W Other: (Please specify)			
No nausea = 0 Mild nausea = 1 Moderate nausea = 2 Severe nausea = 3 No vomiting = 0 1 - 2 times = 1 or 2 More than 2 (Please specify the exact number of times)			
Constipation: Diarrhea: Dry mouth: Fatigue: Other: (Please specify)			

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Date of last treatment:_____________

Weight:____________________lbs_[kg]

Wednesday	Thursday	Friday	Saturday
___/___/___	___/___/___	___/___/___	___/___/___