

# Side Effects Journal

Cycle No. \_\_\_\_\_

**Sunday**

**Monday**

**Tuesday**

<b>Date:</b>	_/_/_	_/_/_	_/_/_
Medication I have taken today. [Including: over-the-counter, prescription, herbal, and/or vitamins] (Please specify)			
Feelings (mood) [0 - 7] (where 0 is very sad and 7 is cheerful) Anxiety [0 - 7] Irritability [0 - 7] Angry feelings [0 - 7] Poor concentration [0 - 7] Thoughts: Self-harm: [SH] Harming others: [H] Suicidal ideas: [Su] Activity Levels [0 - 7] (where 7 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: [C] Diarrhea: [D] Dry mouth: [DM] Fatigue: [Fa] Headache: [H] Chest pain: [CP] Abdominal pain: [AP] Breathlessness: [Br] Visual disturbance: [V] Dizziness: [Diz] Sleep disturbance: [S] Other: (Please specify)			

