



## Self-Care During Cancer Treatment

### General Information

Patient name:

Patient date of birth:

Patient phone number:

### Do you have any of these symptoms today?

<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Pain
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Hand-foot syndrome
<input type="checkbox"/>	Swelling	<input type="checkbox"/>	Skin rash or sores
<input type="checkbox"/>	Numbness & tingling	<input type="checkbox"/>	Nausea & vomiting
<input type="checkbox"/>	Mouth problems	<input type="checkbox"/>	Lack of appetite
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Cough		

### How concerned are you today about...?

<input type="checkbox"/>	Feeling irritable
<input type="checkbox"/>	Changes in work/school/home life
<input type="checkbox"/>	Feeling sad or depressed
<input type="checkbox"/>	Body image & feelings about how you look
<input type="checkbox"/>	Feeling nervous or afraid
<input type="checkbox"/>	Worry about the future
<input type="checkbox"/>	Making a treatment decision
<input type="checkbox"/>	Intimacy, sexual functioning & fertility
<input type="checkbox"/>	Feeling lonely or isolated
<input type="checkbox"/>	Health insurance or money worries
<input type="checkbox"/>	Feeling too tired
<input type="checkbox"/>	You relationship with a spouse or partner
<input type="checkbox"/>	Worry about family, children & friends