

Appointment Record

Appt. Date: _____ Appt. Time: _____ Appt. Location: _____

Exam Visit									
Information to Report:									
<i>Pain Scale</i>									
no pain			moderate pain				extreme pain		
1	2	3	4	5	6	7	8	9	10
<i>Fatigue Scale</i>									
no pain			moderate pain				extreme pain		
1	2	3	4	5	6	7	8	9	10
<i>Anxiety & Depression (Distress) Scale</i>									
no pain			moderate pain				extreme pain		
1	2	3	4	5	6	7	8	9	10
<i>Treatment Side Effects</i> _____									

Exam Results
Lab Results _____

Test Results _____

Exam Results _____

Treatment Planning
Radiation Therapy - Questions to ask (p 23 of <i>Cancer Care Guide</i>)
Start Date _____
Treatment Schedule _____

Chemotherapy - Questions to ask (p 20 of <i>Cancer Care Guide</i>)
Start Date _____
Treatment Schedule _____

Treatment Notes _____

Care at Home		
Medication	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
OTC Medication	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
Diet/Nutrition _____		

Exercise _____		

Special Needs _____		

Questions & Answers / Notes

