

SYMPTOM & VITALS DIARY

Cycle: _____ / Day: _____ **24/7**
Hotline: _____

Key Information & Safety Checks

Start Date of Cycle: _____ / _____ / _____

Medications Added/Stopped This Week: _____

Daily Symptom Tracker (1-Week View)

Scoring Scale: 0=None, 1-3=Mild, 4-6=Moderate (Needs meds), 7-10=Severe (Needs call to hotline)

Time	Day	Date	Temp (°C)	Fatigue (0-10)	Nausea (0-10)	Appetite (0-10)	Notes / Red Flags (Pain, Other)
AM	1						
PM	1						
AM	2						
PM	2						
AM	3						
PM	3						
AM	4						
PM	4						
AM	5						
PM	5						
AM	6						
PM	6						
AM	7						
PM	7						

Specific Events & Questions

Bowel / Tummy Check

Times anti-diarrhea taken / Last bowel movement:

Other Important Observations

New mouth soreness, tingling in hands/feet (neuropathy):

Fluid Intake / Sleep

Total fluid glasses/litres & Sleep quality/hours:

Medication Timing Check

Any missed/late doses of crucial medications (e.g., anti-nausea):

Call Log: Urgent Advice

If you called the hotline, what time, and what was the advice?

REMINDER: Take this entire diary to every clinic appointment.

This document is designed for self-reporting and should not replace professional medical advice.