# **My Health Diary**

For patients undergoing cancer treatment

Please bring this <u>each time</u> you visit the Cancer Centre.
Show your Care Team this book.

This diary can track
4 weeks of information.
Get more copies at <a href="https://www.rvh.on.ca">www.rvh.on.ca</a>,
or in the Cancer Centre
waiting areas.

Track your symptoms, bloodwork results and medications.



## Why you should use this booklet:

- Track how you are feeling during treatment
- Communicate with your Care Team about your symptoms
- Keep an organized record of your health



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### **My Medications**

By keeping track of all the types of medications you take, we can check:

- That you are taking the right type of medications for your health
- If one drug reacts with another in an unwanted way (called drug-drug interactions)
- That everyone is clear about the medications that you should and should not be taking

Be sure to let your doctor/nurse/pharmacist know if this list changes.

### **Prescription Medications**

These are medications that you need a prescription (or doctor's note) to take.

Medicine name	What is it for?	How much do I take?	How often?

Flip over to continue...

#### **Over-the-counter medications**

These are medications that you can buy at a drug store without a doctor's note. For example: pain killers, antacids, allergy medications.

Medicine name	What is it for?	How much do I take?	How often?

## Vitamins, supplements and natural remedies

Medicine name	What is it for?	How much do I take?	How often?

Are you thinking of or taking vitamins, supplements and natural remedies but are not sure if it's safe to take with your cancer drugs? Talk to your nurse or doctor.

Our dietitians at the Simcoe Muskoka Regional Cancer Centre are also here to help! Call 705-728-9090 x43520 for an appointment.



## My Bloodwork

Your doctor may decide that you need regular blood tests. Write in the date of each blood test and your blood counts.

Date	Hemoglobin (g/L)	Platelets (10 <sup>9</sup> /L)	White Cells (10 <sup>9</sup> /L)	Neutrophils (10 <sup>9</sup> /L)	Transfusions (no. of units)	

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Date: Month	Day_ Chemo Cycle Number:	What did you do to help?	What day did the sign/symptom happen?								
If you have:	Describe the sign/symptom:		MON	TUES	WED	THUR	FRI	SAT	SUN		
Pain	Rate from 0 to 10 0 = no pain to 10 = worst pain you've ever had										
Tiredness	Rate from 0 to 10 0 = not tired at all to 10 = most tired you've ever been										
Sleep	Write NO on the days you did not sleep at night										
Nausea	Rate from 0 to 10 0 = not nauseous at all to 10 = most nauseous you've ever been										
Vomiting	Write number of times you vomited that day										
Loss of appetite	Rate from 0 to 10 0 = normal (good appetite) 10 = no appetite at all										
Diarrhea	Write number of times you had a bowel movement that day										
Constipation	Write NO on the days you did not have a bowel movement										
Temperature	If temperature above 38.3°C (or 100.9°F) OR Above 38.0°C or 100.4°F for at least one hour. GO TO YOUR NEAREST EMERGENCY. BRING FEVER CARD										
Numbness (feet/hands)	Write YES on the days you have numbness in your feet/hands										
Skin/nail changes	Write YES on the days you have skin/nail changes										
Sore throat/ mouth	Write YES on the days you have a sore throat/mouth										
Emotional well-being	Use OOO or a 0-10 scale to rate your well-being										

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