Side effect diary

One row per symptom, each time you notice it. Leave a day blank if nothing came up.

Name _____ **Week of** _____

How strong, 0 to 10: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 = not at all, 10 = the worst you can imagine

Use the same words each time, for example:

nausea · vomiting · diarrhea · constipation · heartburn · bloating · tired · headache · site redness · other

This week

DAY	TIME	SYMPTOM	HOW STRONG 0 to 10	POSSIBLE TRIGGER meal, shot day, sleep, stress	NOTES how long, what you tried, did it pass
Day 1 _____ Date					
Day 2 _____ Date					
Day 3 _____ Date					
Day 4 _____ Date					
Day 5 _____ Date					
Day 6 _____ Date					
Day 7 _____ Date					

For personal record keeping. Not medical advice. Share it with your care team.

Protein, fiber and water tally

Write grams from labels or your best estimate. Tick one circle per glass or bottle of water.

My daily protein goal (g) _____ **Fiber goal (g)** _____ **Water goal** _____

Goals from your care team or your app. Leave them blank if you have none yet.

This week

DAY	PROTEIN (G) BKFST	LUNCH	DINNER	SNACKS	PROTEIN TOTAL	FIBER TOTAL (G)	WATER one circle per glass	NOTES appetite, energy, meals that sat well
Day 1 Date							○○○○○○ ○○○○○○	
Day 2 Date							○○○○○○ ○○○○○○	
Day 3 Date							○○○○○○ ○○○○○○	
Day 4 Date							○○○○○○ ○○○○○○	
Day 5 Date							○○○○○○ ○○○○○○	
Day 6 Date							○○○○○○ ○○○○○○	
Day 7 Date							○○○○○○ ○○○○○○	

Patterns I noticed this week

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Questions for my care team

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