


















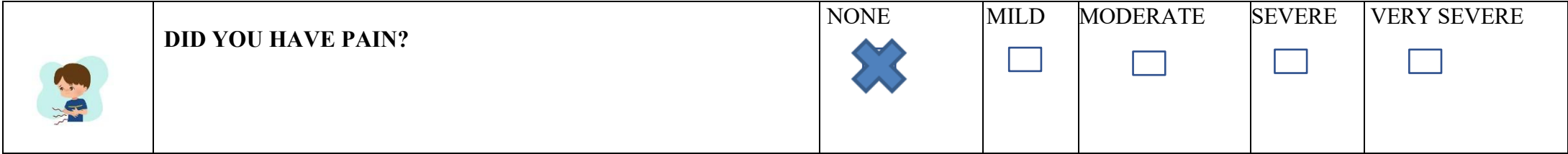
	<p>DID YOU HAVE MOUTH PROBLEMS?</p> <p>(Dry mouth, difficulty swallowing, cracking at the corners of the mouth (cheilosis/cheilitis), taste changes, inflammation, etc...)</p> <p>If YES,</p> <p>which</p> <p>one.....</p> <p>.....</p>	<p>NONE</p> 	<p>MILD</p> <input type="checkbox"/>	<p>MODERATE</p> <input type="checkbox"/>	<p>SEVERE</p> <input type="checkbox"/>	<p>VERY SEVERE</p> <input type="checkbox"/>
	<p>DID YOU HAVE GASTROINTESTINAL PROBLEMS?</p> <p>(Nausea, vomiting, diarrhea, constipation, decreased appetite)</p> <p>If YES,</p> <p>which</p> <p>one.....</p> <p>.....</p>	<p>NONE</p> 	<p>MILD</p> <input type="checkbox"/>	<p>MODERATE</p> <input type="checkbox"/>	<p>SEVERE</p> <input type="checkbox"/>	<p>VERY SEVERE</p> <input type="checkbox"/>
	<p>HAVE YOU HAD RESPIRATORY DIFFICULTIES?</p> <p>(Cough, shortness of breath, wheezing, others)</p> <p>If YES,</p>	<p>NONE</p> 	<p>MILD</p> <input type="checkbox"/>	<p>MODERATE</p> <input type="checkbox"/>	<p>SEVERE</p> <input type="checkbox"/>	<p>VERY SEVERE</p> <input type="checkbox"/>



	which one..... 					
	DID YOU HAVE TEMPERATURE? If YES, what was the maximum temperature TC.....	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>
	DID YOU HAVE SOME SKIN VARIATION? (Rash, colour variation, skin dryness, others) If YES, which one..... 	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>
	DID YOU HAVE SOME NAIL CHANGE? (Nail loss, Nail ridging , Nail discoloration, others) If YES, which one	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>



					
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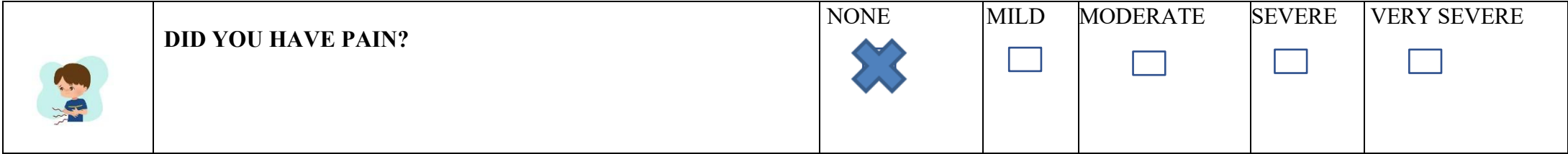
	<p><u>SPECIFIC for RADIOTHERAPY</u></p> <p>DID YOU HAVE ANY REDNESS OR BURNING ON YOUR SKIN?</p> <p>If YES, where</p> <p>.....</p> <p>.....</p>	NONE <input type="checkbox"/>	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>
	<p><u>SPECIFIC for RADIOTHERAPY</u></p> <p>DID YOU HAVE SOME HEAD AND NECK PROBLEM?</p> <p>(Difficulty swallowing , mouth/throat sores, mouth inflammation, dry mouth, other...)</p> <p>If YES,</p> <p>which one</p> <p>.....</p>	NONE <input type="checkbox"/>	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>



					
	DID YOU HAVE HITC? If YES, where..... 	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>
	DID YOU HAVE SOME HAND OR FOOT PROBLEM? (Edema, dryness of skin, alteration of sensibility, other) If YES, which one 	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>
	DID YOU HAVE FATIGUE/TIREDNESS? (Fatigue, lack of energy, weakness)	NONE 	MILD <input type="checkbox"/>	MODERATE <input type="checkbox"/>	SEVERE <input type="checkbox"/>	VERY SEVERE <input type="checkbox"/>

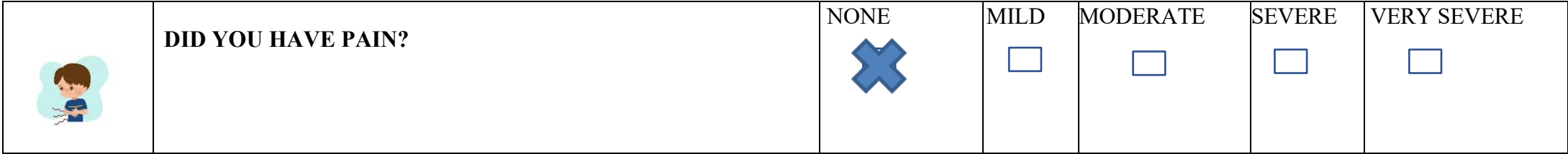




	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

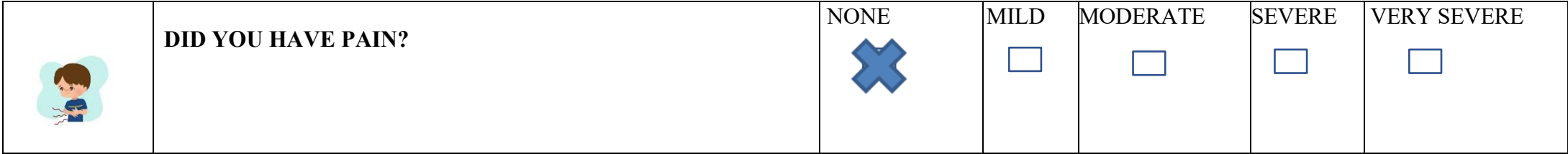
	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





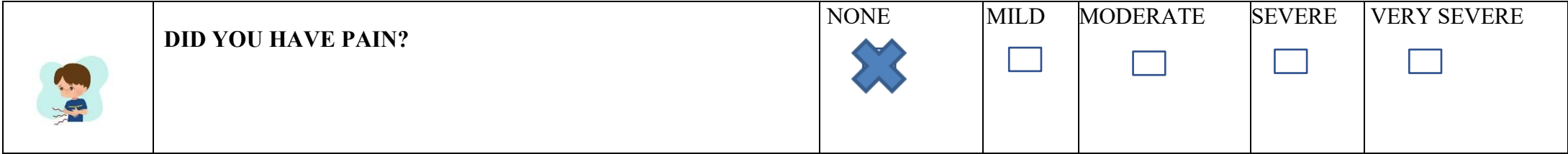
	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





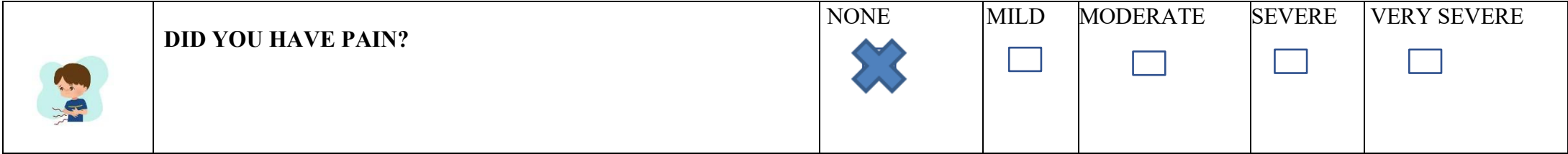
	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	DID YOU HAVE PAIN?	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



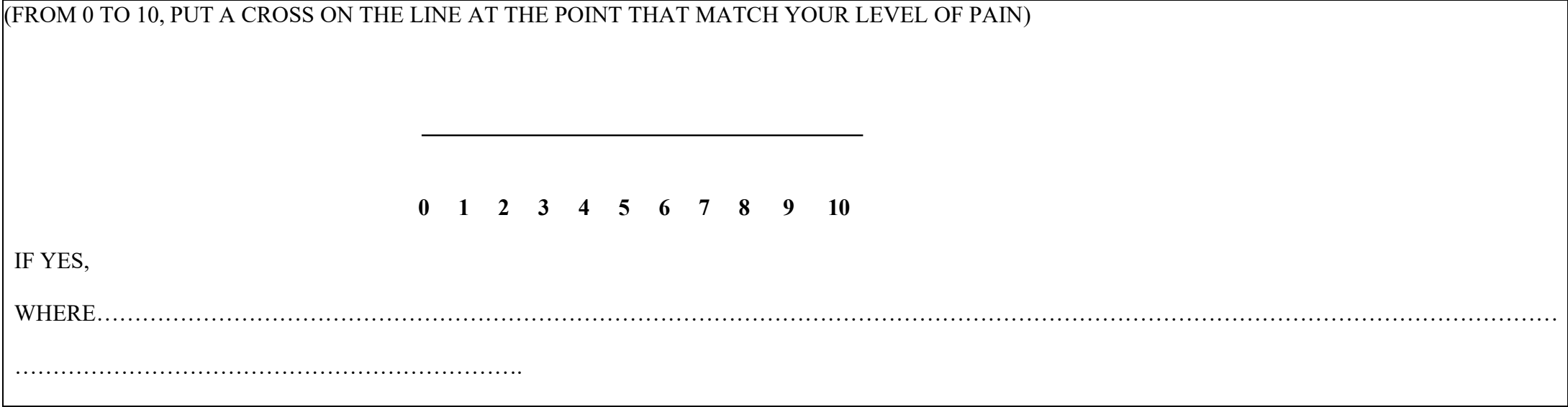
(FROM 0 TO 10, PUT A CROSS ON THE LINE AT THE POINT THAT MATCH YOUR LEVEL OF PAIN)

0 1 2 3 4 5 6 7 8 9 10

IF YES,

WHERE.....

.....



(FROM 0 TO 10, PUT A CROSS ON THE LINE AT THE POINT THAT MATCH YOUR LEVEL OF PAIN)

0 1 2 3 4 5 6 7 8 9 10

IF YES,

WHERE.....

.....