Questions?

Your questions are important. Call your doctor or health care provider if you have questions or concerns. UWMC clinic staff are also available to help.

UWMC phone:

_____

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
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Patient Journal

Your 3-day record

This booklet will help you record your daily progress. Your Patient Journal is a 3-day record to track your food and fluid intake, tube feedings, medicines, and side effects you may be having.

Record each entry as soon as possible:

- **After you eat or drink**
- **After each medicine**
- **When you have a troubling side effect**

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How to Use this Journal

Please record your:

- Food and fluid intake and tube feedings
- Medicines
- And any side effects you are having

Keep these records for 3 days, or until your next visit with your doctor.

Feedings and Fluid Intake

Write down the time you eat and the amount you eat or drink, or the time and amount of your tube feeding. Use the measurements that you prefer. Here are some measurement conversions you may find helpful:

- 1 cc = 1 ml
- 1 ounce = 30 ml = 2 tablespoons
- 60 cc syringe = 2 ounces
- 16 tablespoons = 1 cup
- 4 cups = 1,000 ml = 240 cc

Medicines

Write down the time, the name, and the dose of the medicines you are taking.

Notes

Notes

Side Effects

Write down your symptoms so we can help you better. List and rate your:

- Pain
- Nausea
- Vomiting
- Heartburn
- Constipation
- Diarrhea

Symptoms Scale

Use this scale to rate your symptoms:

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate		Distressed		Horrible		Intolerable	

Day 1 Patient Record

Time	Food, Fluid, or Tube Feeding	Amount	Medicine	Amount

Day 3 Patient Record

Nausea? Rate 0-10	Pain? Rate 0-10	Did medicine work?	Did you vomit? Secretions? Food?	Any other problems?

Day 3 Patient Record

Time	Food, Fluid, or Tube Feeding	Amount	Medicine	Amount

Day 1 Patient Record

Nausea? Rate 0-10	**Pain?** Rate 0-10	**Did medicine work?**	**Did you vomit?** Secretions? Food?	**Any other problems?**

Day 2 Patient Record

Time	Food, Fluid, or Tube Feeding	Amount	Medicine	Amount

Day 2 Patient Record

Nausea? Rate 0-10	**Pain?** Rate 0-10	**Did medicine work?**	**Did you vomit?** Secretions? Food?	**Any other problems?**