Immune Checkpoint Inhibitor Therapy: Monitoring Checklist for Patients

Track symptoms daily. Report to your health care provider if you develop any of the symptoms listed, or if they get worse.

Patient Name: _____ **Week of:** _____

Symptoms	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Lung Shortness of breath New or worse cough Chest pain	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Skin Rash Itching Peeling, blisters Sores in mouth	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Gastrointestinal Diarrhea (volume) Blood or mucus in stool Abdominal pain Nausea or vomiting	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Hormone Glands Rapid heart rate Fatigue Weakness Weight loss or gain Feeling more hungry or thirsty Muscle aches Headaches High or low blood sugars (diabetics)	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Neurologic Weakness Confusion Numbness of hands or feet	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Kidney Change in amount or color of urine	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Vision Change in vision Double vision Eye pain Eye redness	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:
Musculoskeletal Muscle or joint aches Joint swelling Trouble walking or standing	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes:	Yes ☐ No ☐ Notes: