CIOSK
COMMUNITY
IMMUNO-ONCOLOGY
SUPPORT KIT

PATIENT MONITORING QUESTIONNAIRE

Patient name: _____ Date: _____

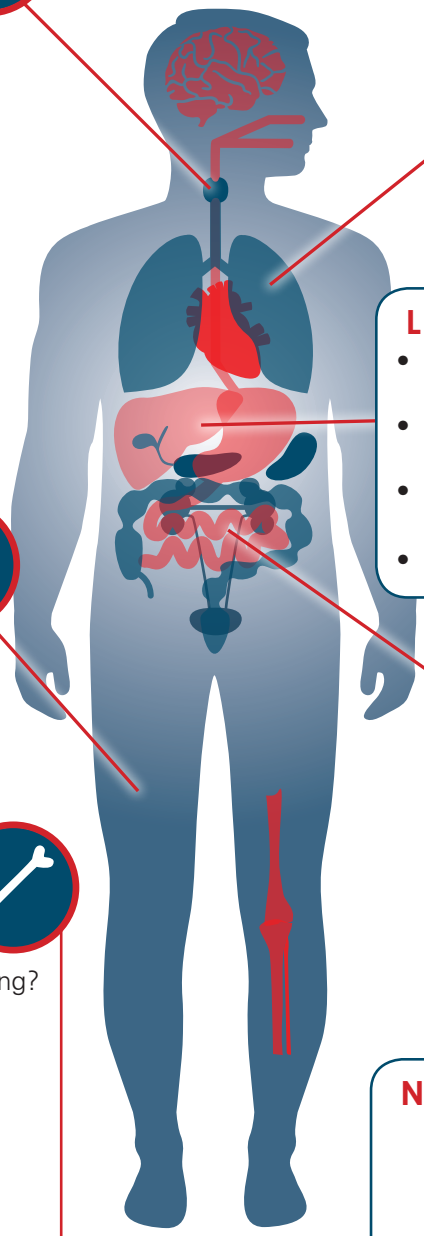
This checklist is intended for healthcare professionals to use prior to dosing each patient and at any follow-up visit or call with the patient to identify some signs and symptoms associated with adverse reactions related to immuno-oncology therapy. Adverse reactions from immuno-oncology therapies may differ from those observed with chemotherapy and targeted therapy and may require immunosuppression. Early identification of adverse reactions and intervention are important for the safe use of immuno-oncology therapies. Please note: this checklist is not meant to be all-inclusive. If the patient responds "Yes" to any of these questions, consult the patient's oncologist before administering further immuno-oncology treatment.

ENDOCRINE

- Have you had persistent or unusual headaches? Yes / No
- Any dizziness or fainting? Yes / No
- Any unusual weight loss/gain? Yes / No
- Any changes in your eyesight? Yes / No
- Have you felt hotter or colder than usual? Yes / No
- Have you felt tired/sluggish? Yes / No
- Have you felt your heart racing? Yes / No
- Have you had a change in hunger/thirst? Yes / No

LUNGS

- Have you had any shortness of breath or trouble breathing? Yes / No
- Do you have new or worsening cough? Yes / No



LIVER

- Has your urine been darker than normal? Yes / No
- Do you notice your skin or whites of your eyes turning yellow? Yes / No
- Do you have pain on the right side of your belly? Yes / No
- Do you easily bruise or bleed? Yes / No

SKIN

- Do you have a rash? Yes / No Where? _____
- Does your skin itch? Yes / No
- Do you have skin blisters or peeling? Yes / No

DIGESTION

- How many times do you have a bowel movement each day? _____Is this different than normal? Yes / No
- Do you have watery or foul-smelling stools? Yes / No
- Are your stools dark, tarry or sticky? Yes / No
- Have you experienced any pain in your belly?Yes / No

OTHER

- Any fever or chills? Yes / No
- Have you experienced additional swelling? Yes / No
- Any change in pain frequency/severity? Yes / No
- Do you have sores or dryness in your mouths? Yes / No
- Do you have any other troublesome symptom(s) that I have not asked you about today? Yes / No
- Are you taking any new medications? Yes / No If yes, which and how often?

NOTES