Patient's Name:_______________________________ Date:________________

ACNEIFORM RASH

<table>
<tr><td>Normal
• Refer to pretreatment nursing or oncology assessment</td><td></td></tr>
<tr><td>Onset
• When did changes start?
• How are changes progressing?
• When was your last treatment?</td><td></td></tr>
<tr><td>Provoking / Palliating
• What makes the symptoms better? Worse?</td><td></td></tr>
<tr><td>Quality
• Do you have any tingling, burning, pain, blisters, ulceration, erythema, dryness, edema, white scaling lesions, peeling skin or severe discomfort to your skin?
• When did symptoms begin?
• Can you describe the nature of the symptom?</td><td></td></tr>
<tr><td>Region / Radiation
• Where are the changes happening (eg. face, torso, arms, scalp)?</td><td></td></tr>
<tr><td>Severity / other Symptoms
• How bothersome is this to you? (0-10 scale, with 0 not at all – 10 being worst imaginable)
• Have you been experiencing any other symptoms?</td><td></td></tr>
<tr><td>Treatment
• Have you used tried any strategies to avoid irritants, heat, and mechanical irritation?
• Are you using any creams or ointments? If so, what type and have they been effective?
• Are you using any pain medications? If so, what type (topical, systemic)? Effective?
• Any other medications or treatments? (e.g. Vitamin B_6)</td><td></td></tr>
<tr><td>Understanding / Impact on You
• Are these symptoms affecting your daily life and if so, how?</td><td></td></tr>
<tr><td>Value
• What is your comfort goal or acceptable level for this symptom (0 – 10 scale)?</td><td></td></tr>
</table>

Created: September 2016 Revised: