Patient's Name:_____ **Date:**_____

FATIGUE

Normal • What is your normal energy/activity level?	
Onset • When did the fatigue begin? Did it start suddenly or gradually over time? • How long does it last? • Does it follow the same pattern every day? • Is it related to a change in cancer treatment?	
Provoking / Palliating • What brings on the fatigue? • Is there anything that makes the fatigue better? Worse? • When do you feel the most tired?	
Quality • Describe the feeling of fatigue in your own words. • Does your body feel tired? • Does your mind feel tired?	
Region / radiation –Not Applicable	
Severity / Other Symptoms • Since your last visit, how would you rate your fatigue between 0-10 with 0 being no fatigue and 10 being the worst fatigue possible?? What is it now? At worst? At best? On average? • Do you have any other accompanying symptoms such as shortness of breath at rest or with activity, rapid heart rate, and chest pain or leg heaviness? • Have you had any changes in your mood or ability to concentrate?	
Treatment • How have you or the health care team tried to manage your fatigue in the past? Any medications? Has this been effective? Any side effects? • Have you had a blood transfusion? When? • When was your last cancer treatment?	
Understanding / Impact on You • How much distress does fatigue contribute to your life? How is your fatigue impacting your activities of daily living (ADL)? • How many hours do you sleep at night? In the day?	
Value • What do you believe is causing this symptom? How is this impacting you and/or your family? • What is your comfort goal or acceptable level for this symptom? (0-10)	

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