Patient's Name:______________________________ **Date**______________________

RADIATION DERMATITIS

Normal • What is the condition of your skin normally? • What are your normal hygiene practices?	
Onset • When did the changes in your skin begin?	
Provoking / Palliating • What makes it feel better or worse?	
Quality (in the last 24h) • Do you have any pain, redness, dry or scaling skin, blisters or drainage? • Do you have any swelling?	
Region • What areas are affected?	
Severity / Other Symptoms • Since your last visit, how would you rate the discomfort associated with the skin reaction? Between 0-10? What is it now? At worst? At best? On average? • Have you been experiencing any other symptoms: fever, discharge, bleeding	
Treatment • When was your last cancer treatment (radiation or chemotherapy)? • How have you been managing the radiation dermatitis (cream, ointments, dressings)? • Are you currently using any medications (analgesic, antibiotic, antifungal)? How effective are they? Any side effects?	
Understanding / Impact on You • Is your dermatitis and treatment impacting your activities of daily living (ADL)? • Do you require any support to (family, home care nursing) complete your skin care routine? • Are you having any difficulty sleeping? Eating? Drinking?	
Value • What is your comfort goal or acceptable level for this symptom?	

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