

## External Radiation Side Effects Worksheet

External radiation therapy uses strong beams or waves of energy to treat certain cancers and other problems caused by cancer. External radiation usually only affects the area of the body getting radiation. Radiation kills cells that grow fast, even if they're not cancer cells. Some healthy cells around the tumor can also be harmed. Visit [cancer.org/radiation](https://www.cancer.org/radiation) to learn more about radiation therapy.

It is important to keep track of any side effects you are having so your cancer care team can help you manage them. This worksheet will help you do that.

Listed on the following pages are the most common side effects people receiving radiation therapy might have.

- You may have none, some, or all of these side effects, or you may have others not listed here.
- We have included suggestions to help you describe each of these side effects to your doctor.
- **Ask your cancer care team when you should call their office right away about certain side effects.** Write these on the last page of this worksheet.

**Print or save a copy of the worksheet for each week that you are receiving treatment and take the worksheet with you when you visit the doctor.**

### How to Use This Worksheet

- This worksheet will cover 1 week (5 treatment days in a week) of radiation therapy. You will need to print additional worksheets for each treatment week.
- For each day of the week, go to the column for that day and check the box that describes how bad each side effect is. If you do not have a particular side effect, check the "None" box.
- Write down what medicines you took to treat the side effect, or what you did that might have helped you feel better.
- **If you have a side effect that can be described as severe, contact your cancer care team right away.**

**Ask your cancer care team which side effects are most common with your radiation treatment, how long they might last, how bad they might be, and when you should call the cancer care team.**

Date	/ /	/ /	/ /	/ /	/ /
	Day 1	Day 2	Day 3	Day 4	Day 5
<b>Common general side effects</b>					
<b>Fatigue (Feeling Weak):</b> None Mild – Relieved by rest Moderate – Not relieved by rest, unable to do household or work activities Severe – Not relieved by rest, unable to take care of self, having trouble walking, or have a fall*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Skin Changes</b> (in areas where radiation therapy is given): None Mild – Light redness, dryness, itchiness, and scaling Moderate – Redness or moist peeling, especially at skin folds* Severe – Swelling and moist peeling in large area or ulcer in skin*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Fever (With or Without Chills):</b> Write down your highest temperature for the day. None – Temperature 98.6° F Mild – Fever 98.6° F to 100.4° F Moderate – Fever 100.4° F to 104° F* Severe – Fever greater than 104° F*	_____ ° F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____ ° F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____ ° F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____ ° F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____ ° F <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>If you are receiving radiation to the head or neck area:</b>					
<b>Sore Mouth (Mucositis):</b> None Mild – Soreness, or painless ulcers Moderate – Soreness or painful ulcer but can eat* Severe – Severe pain with trouble eating*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>Dry Mouth (Xerostomia):</b> Decreased saliva Thick saliva No saliva	<input type="checkbox"/> Decreased <input type="checkbox"/> Thick <input type="checkbox"/> No Saliva	<input type="checkbox"/> Decreased <input type="checkbox"/> Thick <input type="checkbox"/> No Saliva	<input type="checkbox"/> Decreased <input type="checkbox"/> Thick <input type="checkbox"/> No Saliva	<input type="checkbox"/> Decreased <input type="checkbox"/> Thick <input type="checkbox"/> No Saliva	<input type="checkbox"/> Decreased <input type="checkbox"/> Thick <input type="checkbox"/> No Saliva
<b>Nausea and Vomiting:</b> None Mild – Can eat Moderate – Eating/drinking less than normal Severe – Can't eat or drink*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>*Let your cancer care team know about this side effect right away.</b>					

# External Radiation Side Effects Worksheet

Week # \_\_\_\_\_

Date	/ /	/ /	/ /	/ /	/ /
	Day 1	Day 2	Day 3	Day 4	Day 5
<b>If you are receiving radiation to the breast:</b>					
<b>Skin Changes</b> None Mild – Light redness, dryness, or itching. Moderate – Redness or moist peeling, especially at skin folds* Severe – Swelling and moist peeling in large area*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Sore Breast</b> Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Swelling of Breast/Chest Wall/Arm (Lymphedema):</b> None Mild – minor swelling, faint changes in skin color, some thickening of skin Moderate – visible swelling, skin tightness or hardness, change in skin color or texture, some difficulty lifting or moving arms or legs* Severe – severe swelling, very dry or thick skin, fluid leaking from skin, blisters on skin, difficulty lifting or moving arms or legs*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>*Let your doctor know about this right away.</b>					

Date	/ /	/ /	/ /	/ /	/ /
	Day 1	Day 2	Day 3	Day 4	Day 5
<b>If you are receiving radiation to the abdomen:</b>					
<b>Nausea and Vomiting:</b> None Mild – Can eat Moderate – Eating/drinking less than normal Severe – Can't eat or drink*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken here —>					
<b>Diarrhea:</b> (Write down number of bowel movements in a day.) None – Same number of stools as usual Mild – 1 to 3 more stools than usual Moderate – 4 to 6 stools per day more than usual* Severe – 7 or more stools than usual; weakness or dizziness*	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	# of BMs: _____ <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken here —>					
<b>Constipation:</b> None Mild – Using stool softener or laxatives from time to time Moderate – Using laxatives or enemas most days or every day* Severe – Unable to move bowels despite medicine; symptoms interfere with self-care*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken here —>					
<b>*Let your cancer care team know about this side effect away.</b>					



Every cancer. Every life.™

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Week # \_\_\_\_\_

Date	/ /	/ /	/ /	/ /	/ /
	Day 1	Day 2	Day 3	Day 4	Day 5
<b>If you are receiving radiation to the chest:</b>					
<b>Pain or difficulty with swallowing:</b> None Mild – Pain but can eat a regular diet Moderate – Pain that causes trouble eating a regular solid diet* Severe – Can't eat regular solid foods or choking on food/drink*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>Shortness of breath:</b> None Mild – With moderate activity Moderate – With minimal activity* Severe – At rest: Seek immediate treatment*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>Loss of Appetite (Anorexia):</b> None Mild – Loss of appetite but still eating well Moderate – Eating less but little weight loss Severe – Not eating enough to maintain weight*	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Write any medicines taken for this here —>					
<b>If you are receiving radiation to the brain:</b>					
<b>Notify your doctor if you have any of the following:</b> Headache* Seizure* Nausea/vomiting* Decreased hearing/loss* Extreme tiredness (fatigue)* Trouble with memory and speech* Note additional symptoms here —>					
<b>*Let your cancer care team know about this side effect right away.</b>					

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Week # \_\_\_\_\_

Date	/ /	/ /	/ /	/ /	/ /
	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>
<b>List any other side effects you experience in the boxes below.</b>					
<b>Side Effect:</b>          	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Side Effect:</b>          	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<b>Side Effect:</b>          	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe



Every cancer. Every life.™

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Week # \_\_\_\_\_

## Questions to ask my cancer care team

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Which side effects should I notify you about right away? Who should I contact after hours or on weekends or holidays?

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## Notes

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To learn more about radiation therapy, visit the American Cancer Society website at [cancer.org/radiation](https://www.cancer.org/radiation) or call us at **1-800-227-2345**. We're here when you need us.