

Nausea and vomiting scales

Use the assessment scales to measure the degree of CINV that you may be experiencing.
Be sure to tell your doctor or nurse if you are experiencing CINV.

Day 1 Date: ____	Circle the number that tells how you feel today. "1" means you have NO nausea. "10" means you have extreme nausea. 1 2 3 4 5 6 7 8 9 10
Day 2 Date: ____	1 2 3 4 5 6 7 8 9 10
Day 3 Date: ____	1 2 3 4 5 6 7 8 9 10
Day 4 Date: ____	1 2 3 4 5 6 7 8 9 10
Day 5 Date: ____	1 2 3 4 5 6 7 8 9 10

Day 1 Date: ____	Did you vomit today? Yes No If "yes," how many times? <input type="checkbox"/> <input type="checkbox"/> _____
Day 2 Date: ____	Did you vomit today? Yes No If "yes," how many times? <input type="checkbox"/> <input type="checkbox"/> _____
Day 3 Date: ____	Did you vomit today? Yes No If "yes," how many times? <input type="checkbox"/> <input type="checkbox"/> _____
Day 4 Date: ____	Did you vomit today? Yes No If "yes," how many times? <input type="checkbox"/> <input type="checkbox"/> _____
Day 5 Date: ____	Did you vomit today? Yes No If "yes," how many times? <input type="checkbox"/> <input type="checkbox"/> _____

Check any box below if you have that side effect of chemotherapy.

- | | |
|----------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Do not feel hungry (loss of appetite) | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Feeling tired all the time (fatigue) | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Tingling feeling in feet or toes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Other: | |