UTAH DEPARTMENT OF HEALTH SIDE EFFECTS LOG

Patient Name: _____ **Date of Birth:** _____
Initial Weight: _____**kg** **Rx:**_____

Date: Month:	__/__ __1__	__/__ __2__	__/__ __3__	__/__ __4__	__/__ __5__	__/__ __6__	__/__ __7__	__/__ __8__	__/__ __9__	__/__ __10__	__/__ __11__	__/__ __12__
GI symptoms	□	□	□	□	□	□	□	□	□	□	□	□
Joint Pain	□	□	□	□	□	□	□	□	□	□	□	□
Yellow eyes or skin	□	□	□	□	□	□	□	□	□	□	□	□
Vision disturbances	□	□	□	□	□	□	□	□	□	□	□	□
Rash or hives	□	□	□	□	□	□	□	□	□	□	□	□
Flu-like symptoms	□	□	□	□	□	□	□	□	□	□	□	□
Hearing disturbances	□	□	□	□	□	□	□	□	□	□	□	□
Numbness or tingling	□	□	□	□	□	□	□	□	□	□	□	□
Methadone withdrawal*	□	□	□	□	□	□	□	□	□	□	□	□
Dizziness/lightheaded	□	□	□	□	□	□	□	□	□	□	□	□
Unusual bleeding/bruising	□	□	□	□	□	□	□	□	□	□	□	□
Rx stop or held	□	□	□	□	□	□	□	□	□	□	□	□
No adverse reaction	□	□	□	□	□	□	□	□	□	□	□	□
HCW Initials**												

* (≥ 3 new symptoms for ≥ 7 days) nausea and vomiting, abdominal cramps, body aches, restlessness, irritability, dilated pupils, tremors, involuntary twitching, lacrimation, rhinorrhea, sneezing, yawning, excessive perspiration, goose flesh, or diarrhea

****** Printed name for initials: ____ _____ | ____ _____ | ____ _____
Initials Printed name Initials Printed name Initials Printed name

Final Disposition: □Completed treatment □Stopped treatment □ adverse event □ lost to f/u □ moved □ other

Final Disposition Date: _____

Adapted from the Kansas Dept of Health

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Patient Name: _____

Laboratory Log

If levels are abnormal, please describe in Comments section. Include abnormal level(s) and action taken.

	Date	Date	Date	Date	Date	Date	Date	Date
LFT	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____
CBC	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____	normal abnormal _____

Please describe side effects in detail, additional testing done, and remedy

_____
_____
_____
_____
_____
_____
_____
_____

HCW:
Print Name:_____ Signature:_____ Date:_____

Adapted from the Kansas Dept of Health