Patient Reported Side Effects

Date: ____________________

Patient Name: ____________________

Patient ID: ____________________

Medication Name: ____________________

Side Effects Reported:

- Side Effect 1: ____________________
- Side Effect 2: ____________________
- Side Effect 3: ____________________
- Side Effect 4: ____________________

Duration of Side Effects:

From: ____________________ To: ____________________

Severity of Side Effects:

1 (Mild) - 2 - 3 (Moderate) - 4 - 5 (Severe)

Severity Level: ___________

Additional Comments:

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Patient Signature:

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