THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

Patient Name: ____________________
MDACC #: ____________________
Date: ____________________
Inpt Unit / Op Center Name: __________
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SYMPTOM CONTROL & PALLIATIVE CARE
SYMPTOM ASSESSMENT

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**
No Fatigue	0	1	2	3	4	5	6	7	8	9	10	**Worst Fatigue Imaginable**
No Nausea	0	1	2	3	4	5	6	7	8	9	10	**Worst Nausea Imaginable**
No Depression	0	1	2	3	4	5	6	7	8	9	10	**Worst Depression Imaginable**
No Anxiety	0	1	2	3	4	5	6	7	8	9	10	**Worst Anxiety Imaginable**
No Drowsiness	0	1	2	3	4	5	6	7	8	9	10	**Worst Drowsiness Imaginable**
No Shortness Of Breath	0	1	2	3	4	5	6	7	8	9	10	**Worst Shortness of Breath Imaginable**
Best Appetite	0	1	2	3	4	5	6	7	8	9	10	**Worst Appetite Imaginable**
Best Sleep	0	1	2	3	4	5	6	7	8	9	10	**Worst Sleep Imaginable**
Best Feeling Of Wellbeing	0	1	2	3	4	5	6	7	8	9	10	**Worst Feeling of Wellbeing Imaginable**

Assessed by: ____________________