Patient's Name:_____ **Date:**_____

ORAL MUCOSITIS

Normal • Refer to pretreatment nursing assessment or dental evaluation	
Onset • When did symptoms begin?	
Provoking / Palliating • What makes it worse? Better?	
Quality (in last 24 hours) • Do you have a dry mouth? (e.g. decrease in amount or consistency of saliva) • Do you have any redness, blisters, ulcers, cracks, white patchy areas? If so, are they isolated, generalized, clustered, patchy?	
Region / Radiation • Where are your symptoms? (e.g. on lips, tongue, mouth)	

Severity / Other Symptoms
• How bothersome is this symptom to you (0 - 10 scale)?
• Have you been experiencing any other symptoms?
  ○ Fever?
  ○ Difficulty breathing?
  ○ Bleeding?
  ○ Pain?
  ○ Dehydration?	

Treatment • Using any oral rinses? If so, what type? Effective? • Using any pain medications? If so, what type (e.g. topical, systemic)? Effective? • Any other medications or treatments?	

Understanding / Impact on You
• Functional Alterations?
  ○ Ability to eat or drink? How much? Weight loss?
  ○ Taste changes (dysgeusia)?
  ○ Difficulty with speech?
  ○ Able to wear dentures?
  ○ Interfering with other normal daily activity (ADLs)?	

Value • What is your comfort goal or acceptable level for this symptom (0 – 10 scale)?	