MEDICATION LOG

LIST ALL MEDICATIONS															
	am	5													
		4													
		3													
		2													
		1													
		12													
	pm	11													
		10													
		9													
		8													
		7													
		6													
		5													
		4													
		3													
		2													
		1													
		12													
	am	11													
		10													
		9													
		8													
		7													
		6													
		MEDICATION													

(continued on back) →

Please rate how each symptom below bothers you on a scale from 0 to 5 with 5 being the most bothersome problem (Circle one number for each problem)

0= No problem or No Concern 5 = Severe problem or Biggest Concern

Writing	0	1	2	3	4	5
Fine Hand Movement	0	1	2	3	4	5
Bathing, Dressing	0	1	2	3	4	5
Walking	0	1	2	3	4	5
Falls	0	1	2	3	4	5
Freezing	0	1	2	3	4	5
Dyskinesia	0	1	2	3	4	5
Muscle Spasm	0	1	2	3	4	5
Wearing Off	0	1	2	3	4	5
Bladder Problems	0	1	2	3	4	5
Sexual Function	0	1	2	3	4	5
Speech	0	1	2	3	4	5
Swallowing	0	1	2	3	4	5
Sleep	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Motivation	0	1	2	3	4	5
Thinking	0	1	2	3	4	5
Hallucinations	0	1	2	3	4	5
Pain	0	1	2	3	4	5
Constipation	0	1	2	3	4	5
Lightheaded	0	1	2	3	4	5
Chest Pain or Palpitations		Yes			No	
Cough or Sore Throat		Yes			No	
Rash or Bruising		Yes			No	
Leg Swelling		Yes			No	
Joint Pain		Yes			No	
Heartburn or Upset Stomach		Yes			No	
Fatigue		Yes			No	
Seizures		Yes			No	
Hearing Loss		Yes			No	
Double or Blurred Vision		Yes			No	
Headache		Yes			No	

DAILY DIARY OF SYMPTOMS AND MEDICATIONS

Name:_____ **Date:** _____

1. In the medication row, place an X under the hour that you took your medicine; draw a line though the hours that you are asleep.

2. In the dyskinesia row, indicate the severity by entering the correct number. Use the guide below to determine which number is appropriate.
   0 = no extra movement
   1 = mild extra movement
   2 = Moderate movement
   3 = Severe disabling movement

3. For the Off row, indicate if you felt that your medicine is not working using the following guide.
   0 = Feeling no symptoms
   1 = Mild tremor, stiffness or slowness without disability
   2 = Moderate tremor, stiffness or slowness, possibly requiring assistance
   3 = Severe tremor, stiffness or slowness requiring total assistance

	am						pm												am					
TIME	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**	**3**	**4**	**5**
1. Medications *(Place an X at the time of your dose)*																								
2. Dyskinesia *(see scale above)*																								
3. OFF *(see scale above)*																								