

# MY iMCD

## DIARY



☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun Date: \_\_\_\_\_

Infusion day: ☐ Yes ☐ No Was your infusion well tolerated? ☐ Yes ☐ No

If no, make a note of any symptoms you experienced:

Today I generally felt: ☐ 😊 ☐ 😊 ☐ 😊 ☐ 😞 ☐ 😞

Compared to yesterday, I feel: ☐ Better ☐ Worse ☐ Unchanged

How stressful was today? Not at all 1 2 3 4 5 Very

How was your sleep last night? Very bad 1 2 3 4 5 Very good

Today I had the following symptoms (check those that apply) How long did it last? How severe was it? (1: very mild, 5: very severe)

☐ Infection 1 2 3 4 5

☐ Fever 1 2 3 4 5

☐ Limb or muscle pain 1 2 3 4 5

☐ High blood pressure 1 2 3 4 5

☐ Swollen lymph nodes  
Whereabouts on your body? 1 2 3 4 5

☐ Problems with my mouth or throat 1 2 3 4 5

☐ Tummy issues or indigestion 1 2 3 4 5

☐ Weight change ☐ Gain ☐ Loss

☐ Water retention (swelling or puffiness)  
Whereabouts on your body? 1 2 3 4 5

☐ Fatigue/tiredness 1 2 3 4 5

☐ Shortness of breath 1 2 3 4 5

☐ Night sweats 1 2 3 4 5

☐ Skin rash 1 2 3 4 5

☐ Itching 1 2 3 4 5

☐ Cough 1 2 3 4 5

☐ Pain 1 2 3 4 5

☐ Other  
Describe the symptom 1 2 3 4 5

How did your symptoms impact your daily life?