

Patient Details

Treatment Week:

Weight:

Alcohol units per week:

CURRENT DOSE

Interferon _____

Ribavirin _____

DOSE REDUCTION:

Interferon _____

Ribavirin _____

NEW MEDICATION: Yes / No

SIDE-EFFECTS

None	<input type="text"/>	Loss of appetite	<input type="text"/>	Mood swings	<input type="text"/>
Flu-like symptoms	<input type="text"/>	Nausea / vomiting	<input type="text"/>	Anxiety	<input type="text"/>
Headaches	<input type="text"/>	Diarrhoea/Constipation	<input type="text"/>	Irritability	<input type="text"/>
Joint Pains	<input type="text"/>	Mouth ulcers	<input type="text"/>	Poor concentration	<input type="text"/>
Fatigue	<input type="text"/>	Itchy / Dry skin	<input type="text"/>	Depression	<input type="text"/>
Insomnia	<input type="text"/>	Rash	<input type="text"/>	Hair loss / thinning	<input type="text"/>

BLOOD RESULTS

GGT Alk Phos ALT T. Bilirubin Albumin

Glucose HB WBC Platelets Neutrophils

T4 Tsh

Hep C PCR RNA POSITIVE NEGATIVE

COMMENTS

Signature _____ Position _____ Date _____