

**AE Flow Sheets
CC003-Baseline**

Patient Name: _____

Patient ID: _____

Cycle: _____

Date of Evaluation: _____

<u>AE's To Be Evaluated Each Cycle</u>	<u>GRADE</u>						<u>ATTRIBUTION</u>				
							1-unrelated, 2-unlikely, 3-possible 4-probable, 5-definite				
Alopecia	0	1	2	3	4	5	1	2	3	4	5
Dry mouth	0	1	2	3	4	5	1	2	3	4	5
Dysgeusia	0	1	2	3	4	5	1	2	3	4	5
Scalp pain, redness or irritation	0	1	2	3	4	5	1	2	3	4	5
Concentration impairment	0	1	2	3	4	5	1	2	3	4	5
Memory impairment	0	1	2	3	4	5	1	2	3	4	5
Fatigue	0	1	2	3	4	5	1	2	3	4	5
Seizures	0	1	2	3	4	5	1	2	3	4	5
Hearing impairment	0	1	2	3	4	5	1	2	3	4	5
Hypersomnia	0	1	2	3	4	5	1	2	3	4	5
Cataracts	0	1	2	3	4	5	1	2	3	4	5
Nausea	0	1	2	3	4	5	1	2	3	4	5
Vomiting	0	1	2	3	4	5	1	2	3	4	5
Headaches	0	1	2	3	4	5	1	2	3	4	5
Other Adverse Events?	Yes		No		If yes, specify below.						
ADVERSE EVENT CTCAE Version 5.0 Unless Otherwise Stated	GRADE						ATTRIBUTION				
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5
	0	1	2	3	4	5	1	2	3	4	5

OF STOOLS/DAY: 0 1 2 3

NICOTINE USE

Age Started: _____

Cigarettes:

Yes / No # of packs/day _____

PERFORMANCE STATUS: 0 1 2 3 4

Smokeless Tobacco:

Yes / No # of cans/day _____

E-Cigarettes:

Yes / No # of months used _____

INVESTIGATOR SIGNATURE: _____

DATE: _____