Take charge of your PV symptoms

Tracking your symptoms regularly helps you notice patterns, like when fatigue gets worse, or what might trigger itching, brain fog, or headaches.

Using this guide can help you make the most of your time with your doctor by focusing on the aspects of your polycythemia vera (PV) that matter most to you.

My Weekly Symptom Tracker

Stay on top of your PV by writing down how you feel each week and sharing this with your doctor at your next visit.

Rate your symptom severity, and how it interferes with your daily life (your ability to perform daily activities such as working, engaging in social relationships, tasks, etc.)

0=does not interfere, 10=completely interferes

WEEK _____	M	T	W	Th	F	Sa	Su	AVERAGE SCORE *(add week scores together and divide by number of days)*
SYMPTOMS OF IRON DEFICIENCY, WHICH AFFECTS HOW IRON IS TRANSPORTED THROUGH THE BODY								
Fatigue *(tiredness, weariness, feeling run down)*								
Brain fog *(difficulty with concentration)*								
Weakness and dizziness								
Describe *(frequency, time of day, how it impacts your day, etc.)*								
SYMPTOMS DUE TO ENLARGED SPLEEN, WHICH IS RESPONSIBLE FOR PROCESSING RED BLOOD CELLS								
Filling up quickly when you eat								
Stomach (abdominal) pain or discomfort								
Cough								
Describe *(frequency, time of day, how it impacts your day, etc.)*								

Rate your symptom severity, and how it interferes with your daily life (your ability to perform daily activities such as working, engaging in social relationships, tasks, etc.)

0=does not interfere, 10=completely interferes

WEEK _____	M	T	W	Th	F	Sa	Su	AVERAGE SCORE *(add week scores together and divide by number of days)*
FULL BODY SYMPTOMS								
Night sweats								
Itching								
Bone pain *(widely spread; not joint pain or arthritis)*								
Fever *(at least once a week)*								*(If yes, enter actual temperature range)*
Other symptoms: *(headache, sweating, ringing in the ears, etc.)*								
Unintentional weight loss over last 6 months *(10 pounds or more)*				**Yes / No** *(circle an option)*				*(If yes, enter actual weight loss)*
Describe *(frequency, time of day, how it impacts your day, etc.)*								

IMPACT ON QUALITY OF LIFE

How have PV and its symptoms affected your:
(0=does not interfere, 10=completely interferes)

	M	T	W	Th	F	Sa	Su	
Overall quality of life								
Activity levels *(ability to do chores, exercise, etc.)*								
Mood								
Describe *(frequency, time of day, how it impacts your day, etc.)*								

Rate your symptom severity, and how it interferes with your daily life (your ability to perform daily activities such as working, engaging in social relationships, tasks, etc.)

0=does not interfere, 10=completely interferes

WEEK _____	M	T	W	Th	F	Sa	Su	AVERAGE SCORE *(add week scores together and divide by number of days)*
IMPACT ON QUALITY OF LIFE (CONTINUED)								
How have PV and its symptoms affected your: ***(0=does not interfere, 10=completely interferes)***								
Ability to perform at work/maintain your job								
Relationships with other people *(family, social life, etc.)*								

Describe
(frequency, time of day, how it impacts your day, etc.)

_____

_____

Bring this Symptom Tracker to your next doctor visit. Open communication with your doctor can help build a strong partnership and lead to care that meets your individual needs.

Find a guide for a discussion with your doctor here. Scan the QR code to visit RethinkPV.com and talk to your doctor for more information about PV.

Click Here →