



**PROSTATE
CANCER UK**

My hot flush diary

It can help to keep a diary of your hot flushes. Keeping a diary helps you and your doctor or nurse understand how your hot flushes are affecting you and your life. You'll be able to see if there are any situations, drinks or foods that might bring on a hot flush.

The diary can help you to decide whether to have treatment for your hot flushes or whether there are things you can do to manage them. You can take your diary to your appointments with your doctor, nurse or other health professional.

Weekly plan

Fill this in at the start of your week.

Dates: From:


To:

What medicines I'm taking this week for my hot flushes (if any):

What I'm doing this week to try to manage my hot flushes (if anything):

Daily diary

Fill this in every day.

Day	Number of hot flushes in the day	Number of hot flushes at night	How long did they last today? (Tick all that apply)	How did they affect you today? (Tick all that apply)	What do you think might have triggered your hot flushes today? (Tick all that apply)
 Monday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: _____ <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress
Tuesday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: _____ <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress



Day	Number of hot flushes in the day	Number of hot flushes at night	How long did they last today? (Tick all that apply)	How did they affect you today? (Tick all that apply)	What do you think might have triggered your hot flushes today? (Tick all that apply)
Wednesday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: <hr/> <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress
Thursday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: <hr/> <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress
Friday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: <hr/> <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress
Saturday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: <hr/> <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress
Sunday			<input type="checkbox"/> a few seconds <input type="checkbox"/> a few minutes <input type="checkbox"/> more than 10 minutes	<input type="checkbox"/> a bit hot <input type="checkbox"/> quite hot and sweaty <input type="checkbox"/> very hot and sweaty	<input type="checkbox"/> smoking <input type="checkbox"/> alcohol <input type="checkbox"/> caffeine <input type="checkbox"/> spicy food <input type="checkbox"/> hot food <input type="checkbox"/> other: <hr/> <input type="checkbox"/> hot drinks <input type="checkbox"/> changes in temperature <input type="checkbox"/> physical activity <input type="checkbox"/> stress

How did it go?

Fill this in at the end of the week.

This week, how much have hot flushes interfered with these aspects of your life? Circle one number for each aspect of your life.

	Do not interfere 0			Completely interfere 4	
Work	0	1	2	3	4
Social activities	0	1	2	3	4
Hobbies and sports	0	1	2	3	4
Sleep	0	1	2	3	4
Mood	0	1	2	3	4
Concentration	0	1	2	3	4
Relationships	0	1	2	3	4
Sexual activity	0	1	2	3	4

Notes on how my hot flushes have affected me this week:

Action plan

Fill this in at the end of the week.

Things I want to try to help manage my hot flushes next week (tick all that apply):

- stopping smoking or cutting down
- eating less hot food
- getting to a healthy weight
- drinking fewer hot drinks
- drinking less alcohol
- managing changes in temperature
- drinking less caffeine
- changing my physical activity
- eating less spicy food
- managing my stress
- other:

Treatments to ask my doctor, nurse or other health professional about:

Other things to ask my doctor, nurse or other health professional about:

If you have questions about treating or managing hot flushes, speak to our Specialist Nurses on **0800 074 8383** or chat to them online at prostatecanceruk.org