

Record your signs and symptoms of PNH before each appointment and discuss them with your healthcare team.

Please check off the severity of your signs and symptoms.

| My PNH record | Visit 1 Date: | Visit 2 Date: |
|---|---|---|
| Signs and symptoms | | |
| Dark-colored urine | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Shortness of breath | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Difficulty swallowing | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Yellowing of the skin and/or eyes | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Erectile dysfunction | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Have you had a cold or infection since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain | | |
| Stomach pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Leg pain or swelling | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Chest pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Back pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Fatigue | | |
| Tiredness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Inability to perform daily activities | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Trouble concentrating | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Dizziness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Weakness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Lactate dehydrogenase (LDH)* | Value: | Value: |
| Transfusions | Frequency: # of units: | Frequency: # of units: |

*Talk to your healthcare team about other important lab test results.

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| My PNH record | Visit 3 Date: | Visit 4 Date: |
|---|---|---|
| Signs and symptoms | | |
| Dark-colored urine | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Shortness of breath | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Difficulty swallowing | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Yellowing of the skin and/or eyes | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Erectile dysfunction | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Have you had a cold or infection since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain | | |
| Stomach pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Leg pain or swelling | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Chest pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Back pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Fatigue | | |
| Tiredness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Inability to perform daily activities | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Trouble concentrating | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Dizziness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Weakness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Laboratory and Treatment | | |
| Lactate dehydrogenase (LDH)* | Value: | Value: |
| Transfusions | Frequency: # of units: | Frequency: # of units: |

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| My PNH record | Visit 5 Date: | Visit 6 Date: |
|---|---|---|
| Signs and symptoms | | |
| Dark-colored urine | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Shortness of breath | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Difficulty swallowing | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Yellowing of the skin and/or eyes | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Erectile dysfunction | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Have you had a cold or infection since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain | | |
| Stomach pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Leg pain or swelling | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Chest pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Back pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Fatigue | | |
| Tiredness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Inability to perform daily activities | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Trouble concentrating | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Dizziness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Weakness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Lactate dehydrogenase (LDH)* | Value: | Value: |
| Transfusions | Frequency: # of units: | Frequency: # of units: |

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| My PNH record | Visit 7 Date: | Visit 8 Date: |
|---|---|---|
| Signs and symptoms | | |
| Dark-colored urine | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Shortness of breath | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Difficulty swallowing | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Yellowing of the skin and/or eyes | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Erectile dysfunction | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Have you had a cold or infection since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain | | |
| Stomach pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Leg pain or swelling | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Chest pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Back pain | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Fatigue | | |
| Tiredness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Inability to perform daily activities | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Trouble concentrating | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Dizziness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Weakness | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Lactate dehydrogenase (LDH)* | Value: | Value: |
| Transfusions | Frequency: # of units: | Frequency: # of units: |

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