

# Pain Medication Management Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR No: \_\_\_\_\_

Date: \_\_\_\_\_

1. Where is your pain? \_\_\_\_\_

2. Mark with an "X" the words that describe your pain:

- |                                       |                                    |                                      |                                    |                                 |
|---------------------------------------|------------------------------------|--------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Aching       | <input type="checkbox"/> Sharp     | <input type="checkbox"/> Penetrating | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Nagging      | <input type="checkbox"/> Shooting  | <input type="checkbox"/> Burning     | <input type="checkbox"/> Stabbing  | <input type="checkbox"/> Numb   |
| <input type="checkbox"/> Exhausting   | <input type="checkbox"/> Miserable | <input type="checkbox"/> Unbearable  | <input type="checkbox"/> Gnawing   | <input type="checkbox"/> Tiring |
| <input type="checkbox"/> Other: _____ |                                    |                                      |                                    |                                 |

3. Is your pain present:  Occasionally  About 1/2 time  most of the time  constantly

4. Is there a time of the day when your pain is at its worse?  No  Yes

If yes, is it  morning  mid-day  evening  night time

5. DURING THE PAST WEEK, rate your pain by marking with an "X" along the line at the point that best describes your pain:

a. at its worse:

0 100  
NO PAIN ←-----> SEVERE PAIN

b. at its best:

0 100  
NO PAIN ←-----> SEVERE PAIN

c. at its average level:

0 100  
NO PAIN ←-----> SEVERE PAIN

6. When you take your pain medicine, what is the level of your pain?

0 100  
NO PAIN ←-----> SEVERE PAIN

7. Besides not taking your pain medication, what makes your pain worse? \_\_\_\_\_

8. Besides taking your pain medications, what makes your pain better? \_\_\_\_\_

9. If you are having any of these symptoms, please mark with an "X":

- |                                  |                                   |                                       |  |
|----------------------------------|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Nausea  | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Lack of Appetite    |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression   | <input type="checkbox"/> Difficulty thinking |

10. Is there anything else you would like to talk about? \_\_\_\_\_

Please sign: \_\_\_\_\_