PATIENT PAIN DIARY

The goal of the pain diary is to determine an appropriate course of treatment for your pain. During the next 4 hours perform activities that normally cause you pain. DO NOT EXERT YOURSELF. Please fill out this form completely. We will call to review your results following your procedure.

COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)

0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating Unbearable	10 Unimaginable Unspeakable
No Pain	**Minor Pain**			**Moderate Pain**			**Severe Pain**			
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.			Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.			Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.			

Name:________________________________ Today's Date: ____/_____/_____

What procedure did you have done? _____________________ Date of Procedure: ____/____/____

- Using the pain scale above, circle the pain level you experienced prior to the procedure?
  1 2 3 4 5 6 7 8 9 10

- Using the pain scale above, circle the pain level you experienced after the procedure in the PACU (recovery room)?
  1 2 3 4 5 6 7 8 9 10

- Which of the following **BEST** describes your pain? (circle all that apply)
  Aching Throbbing Sharp Burning Dull Pins/Needles

  Shooting Stabbing Pressure Sore Discomfort Cramping Electric Shocks

- What causes the pain to **INCREASE?** (circle all that apply)
  Lying down Sitting Standing Walking Stairs Exercise Chores

  Coughing/Sneezing Showering Morning hours Evening hours Nothing

Specific:____

- What did you do to relieve the pain?
  Medications Cold Compress Hot Compress Reposition Stretch

List medications used:____

Hours following procedure	Pain level and description (Scale 0-10- see above, location, character of pain)	Activity performed (explain what you were doing during this time)	What you did to relieve pain (circle ALL that apply)
0-1 HOUR			Medication Cold compress Hot compress Reposition Rest
1-2 HOURS			Medication Cold compress Hot compress Reposition Rest
2-3 HOURS			Medication Cold compress Hot compress Reposition Rest
3-4 HOURS			Medication Cold compress Hot compress Reposition Rest
4-5 HOURS			Medication Cold compress Hot compress Reposition Rest
5-6 HOURS			Medication Cold compress Hot compress Reposition Rest

Additional comments:

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