

Postsurgical Patient Survey

Patient name: _____

Date: _____

Surgical procedure: _____

Surgery date: _____

For office use only:

Patient no.: _____

Intensity (#6): _____

Relief (#8): _____

MD Signature: _____

Date: _____

1. Have you experienced any pain related to your surgery since your last visit? **yes** or **no**

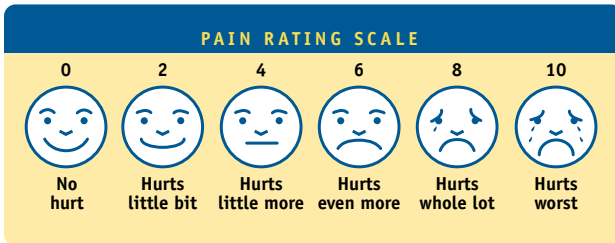
*If you answered **yes**, please continue with question 2.*

*If you answered **no**, please skip to question 10.*

2. How often do you experience this pain?

- Constantly
- At regular times (for example, every 4 hours)
- At irregular times

For questions 3 through 6, please use the pain scale provided below.



3. How would you rate your pain **at its worst** since your last visit? _____

4. How would you rate your pain **at its least** since your last visit? _____

5. How would you rate your pain **on the average** since your last visit? _____

6. How would you rate your pain **at present**? _____

7. What medications are you receiving for your pain?

8. Using the scale below, please rate how much pain relief your medications have supplied since your last visit.



9. Using the scale below, please indicate how much postoperative pain has interfered with aspects of your life (A through G).



- A. General activity _____
- B. Mood _____
- C. Walking ability _____
- D. Normal work (including both work outside the home and housework) _____
- E. Relations with other people _____
- F. Sleep _____
- G. Enjoyment of life _____

10. Please provide any further comments you have on your postoperative pain and/or the therapies you have received for it.
