

Interventional Endoscopy Service Pain Survey

Patient Name: _____ When did the pain begin? _____

Is the pain related to (please check one on each line):

- Meals: worse better no change
- Movement: worse better no change
- Standing: worse better no change
- Lying: worse better no change
- Heat or cold: worse better no change
- Bowel movement: worse better no change
- Passing flatus: worse better no change

- Intensity of the pain (please check all that apply):

- Sharp Aching Burning Dull Throbbing Colicky Pressure-like
 Other: _____

- Location of the pain (please check all that apply):

- Right Left Upper Lower Diffused

- Time of day the pain occurs:

- All day Morning Afternoon Awakens you at night

- Radiation of the pain:

- Back Shoulder Chest Arms Other _____

- Duration of the pain:

- On/off Constant Minutes Hours Days Specify _____

- Frequency of the pain:

- Constant Daily Weekly Monthly Specify _____

- Pain Controlled with:

- Tylenol Narcotic drugs Not controlled Other _____

- Intensity score of the pain (please rate the pain on a 0-10 scale, 10 being the highest score):

