California Pacific
Medical Center

Interventional Endoscopy Services Medical Group
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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):