Persistent Pain — Follow-Up Questionnaire

Patient Name _____ **Date** _____

Please choose the best response to the following questions.

1. How much does your pain interfere with walking?

   Not at all **A little** **Moderately** **A lot**

2. How much does your pain interfere with enjoying your life (socializing, travel, hobbies, and work)?

   Not at all **A little** **Moderately** **A lot**

3. How much does your pain interfere with shopping?

   Not at all **A little** **Moderately** **A lot**

4. How much does your pain interfere with driving?

   Not at all **A little** **Moderately** **A lot**

5. How much does your pain interfere with your ability to exercise?

   Not at all **A little** **Moderately** **A lot**

6. How much does your pain interfere with taking a bath?

   Not at all **A little** **Moderately** **A lot**

7. How much does your pain interfere with getting to the toilet on time?

   Not at all **A little** **Moderately** **A lot**

8. How much does your pain interfere with your ability to think clearly?

   Not at all **A little** **Moderately** **A lot**

9. How much does your pain interfere with your sleep?

   Not at all **A little** **Moderately** **A lot**

10. How much does your pain interfere with your appetite?

    Not at all **A little** **Moderately** **A lot**

11. How much does your pain interfere with your mood and spirits?

Not at all **A little** **Moderately** **A lot**

12. How much does your pain interfere with your relationships with family and friends?

Not at all **A little** **Moderately** **A lot**

13. How much does your pain interfere with your energy?

Not at all **A little** **Moderately** **A lot**

Current Medication(s)

List the current medicines you take for pain and how often you are taking them. You can either say how many and how often, or about how many pills you use in a day for each medicine.

Name of Medication	**Strength and Times per Day**

Review of Symptoms

Have you been bothered by any of the following problems in the past few months? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

Problem	**Description, Date(s)**
Vision or hearing problem	
Lack of energy	
Decreased alertness or fatigue	
Dizziness or unsteadiness	
Passing out spells	
Falls or near falls	
Dry mouth	
Chest pain or discomfort	
Reflux or stomach pain	
Constipation	
Nausea	
Change in appetite	
Weight change	
Swelling	
Night sweats	
Trouble with sleep	
Depression	
Trouble with urination	
Confusion	
Problems having sex	