PAIN DIARY

Patient Name:_____ **Patient Date of Birth:**_____

DATE OF PROCEDURE:_____ **TYPE OF PROCEDURE:**_____

PAIN SCORE ON ADMISSION:_____ **PAIN SCORE UPON DISCHARGE:**_____

Day 1 Post Procedure Hours, Day of the Procedure

Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)	**Main Activites**	**Pain Meds (Type and Strength)**
2 hours after		
4 hours after		
6 hours after		
8 hours after		
10 hours after		
12 hours after		
14 hours after		
16 hours after		
18 hours after		
20 hours after		
22 hours after		
24 hours after		

Day 2

Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)	**Main Activites**	**Pain Meds (Type and Strength)**
Morning		
Afternoon		
Evening		

Day 3	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		
Day 4	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		
Day 5	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		
Day 6	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		
Day 7	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		
Day 8	**Please indicate pain score using a 0-10 scale (0 = no pain, 10 = worst pain)**	**Main Activites**	**Pain Meds (Type and Strength)**
	Morning		
	Afternoon		
	Evening		