Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)
PAIN LOG

Index to Health Diary-Pain\Encounter

Date: _____

Diagnosis: _____ Procedure: _____

Date: _____ End Time: _____

Sedation Meds/Recovery Room: _____

Referring Physician: _____

Signature: _____ Date: _____ Time: _____ Pager# _____

PLEASE COMPLETE THE SECTION BELOW:

Pain Rating Before the Procedure

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain			Severe Pain			Worst Pain Possible

Pain Rating after the Procedure

Rate your pain using the scale above, every hour for eight hours after the procedure is completed.

Hour	Avg. Pain Rating 0-10	Avg % of Pain Relief
1		
2		
3		
4		
5		
6		
7		
8		

Pain Scale Rating for 14 Days after the Procedure.
Continue to rate your pain in comparison to the pain level you identified before your procedure.

Patient Documentation		
Day	Avg. Pain Rating 0-10	Avg. % of Pain Relief
1		
2		
3		
4		
5		
6		
7		

Patient Documentation		
Day	Avg. Pain Rating 0-10	Avg. % of Pain Relief
8		
9		
10		
11		
12		
13		
14		

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Please mail this pain log back to the Pain Clinic in the postage paid envelope.
Please keep a copy of the pain log for yourself. Your feedback is required. We need your input to determine if we do further pain blocks and plan other aspects of your care.

Signature of Patient/Representative _____Date: _____Time: _____AM/PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated
Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ Other _____

Reviewed by: _____ Date: _____ Time: _____AM/PM

	Physician Comment Section
☐	Negative "-" or No response from the block
☐	Equivocal +/-
☐	Positive "+" or Good response
☐	No Comment
	Future Treatment Plan:
☐	See Referring MD for follow-up:
☐	See Pain Clinic:

Signature: _____ Date: _____ Time: _____ Pager# _____