



F308

BASELINE PAIN QUESTIONNAIRE

Instructions: Please use a pen to complete this Questionnaire today, before we conduct your exam.

We want to know if you have had any pain in the last 24 hours. Before you complete this questionnaire, think about what time it is now. Then think back over the last 24 hours. This is the very specific 24-hour time period we are interested in.

There are 3 parts to the Pain Questionnaire. Read the instructions for each section carefully before you complete that section. If you have questions, ask the Research Nurse.

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F308, version 03/27/06 (A)

Section A: General Study Information for Office Use Only

A1. ID#: Label A2. Visit # Baseline .....TBAS
A3. Date Patient Completed: \_\_\_/\_\_\_/\_\_\_ A4. Interviewer's ID: \_\_\_
A5. Date Coded: \_\_\_/\_\_\_/\_\_\_ A6. Coder's ID: \_\_\_
A7. Form Version: English..... 1 Spanish ..... 2
A8. Is this a repeat measure? Yes..... 1 No..... 2

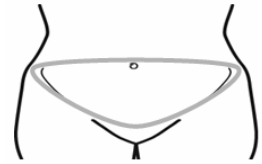
**Body Maps:** Questions in this section ask about pain you might have had in 7 different body areas. There is a picture (body map) for most of these areas in the boxes below to help you understand the specific areas we are asking you about. Read each question and tell us if you had pain in that area in the last 24 hours.

**B1.** Have you had **lower abdominal pain** in the last 24 hours?

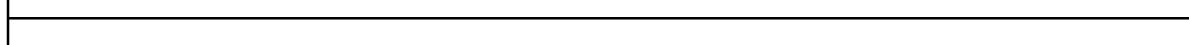
Yes ..... 1 ↓ **COMPLETE B1a & B1b.**

No.....2 → **SKIP TO B2**

B1a. If yes, mark an "X" on the picture at the location of the pain. →




B1b. Rate the intensity of the **lower abdominal pain** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

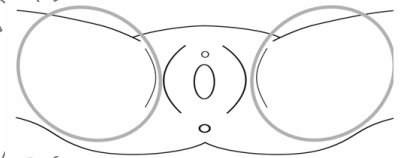
*Most Intense Pain  
Sensation Imaginable*

**B2.** Have you had **inner thigh pain** in the last 24 hours?

Yes ..... 1 ↓ **COMPLETE B2a & B2b.**

No.....2 → **SKIP TO B3**

B2a. If yes, mark an "X" on the picture at the location of the pain. →




B2b. Rate the intensity of the **inner thigh pain** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

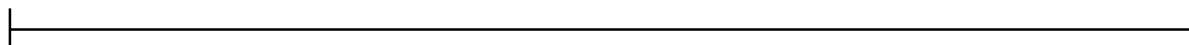
*Most Intense Pain  
Sensation Imaginable*

**B3.** Have you had **pain inside your vagina** in the last 24 hours?

Yes ..... 1 ↓ **COMPLETE B3b.**

No.....2 → **SKIP TO B4**

B3b. Rate the intensity of the **pain inside your vagina** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

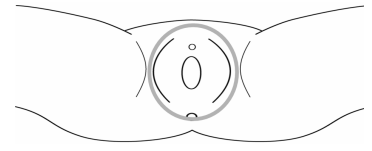
*Most Intense Pain  
Sensation Imaginable*

**B4.** Have you had pain in the area **outside your vagina but inside the thigh crease** in the last 24 hours?

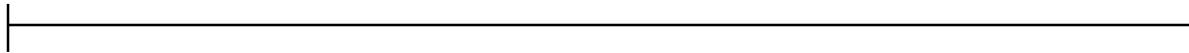
Yes ..... 1 **↓ COMPLETE B4a & B4b.**

No.....2 **➔ SKIP TO B5**

B4a. If yes, mark an "X" on the picture at location of the pain. ➔



B4b. Rate the intensity of the pain **outside your vagina but inside the thigh crease** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

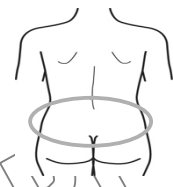
*Most Intense Pain  
Sensation Imaginable*

**B5.** Have you had **lower back pain** in the last 24 hours?

Yes ..... 1 **↓ COMPLETE B5a & B5b.**

No.....2 **➔ SKIP TO B6**

B5a. If yes, mark an "X" on the picture at the location of the pain. ➔



B5b. Rate the intensity of the **lower back pain** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

*Most Intense Pain  
Sensation Imaginable*

**B6.** Have you had **front leg pain** in the last 24 hours?

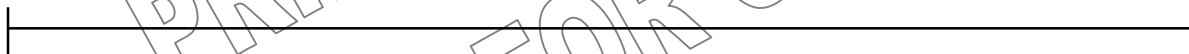
Yes ..... 1 **↓ COMPLETE B6a & B6b.**

No.....2 **➔ SKIP TO B7**

B6a. If yes, mark an "X" on the picture at the location of the pain. ➔



B6b. Rate the intensity of the **front leg pain** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

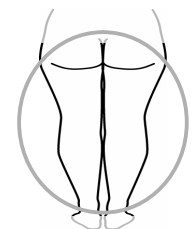
*Most Intense Pain  
Sensation Imaginable*

**B7.** Have you had any pain in the **back of your legs or buttocks** in the last 24 hours?

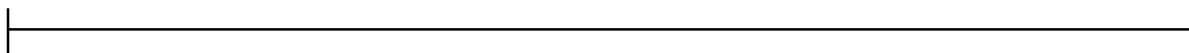
Yes ..... 1 **↓ COMPLETE B7a & B7b.**

No.....2 **➔ SKIP TO C1**

B7a. If yes, mark an "X" on the picture at the location of the pain. ➔



B7b. Rate the intensity of the **pain in the back of your legs or buttocks** by marking a vertical line through the pain scale below.



*No Pain  
Sensation*

*Most Intense Pain  
Sensation Imaginable*

## Use of Pain Medication:

We also want to know about any pain medicines you took in the last 24 hours. We want to know about both prescribed **and** over-the-counter pain medicines.

**D1.** Did you use any pain medicines in the last 24 hours?

Yes .....1 ↓

No .....2 → **GO TO END.**

**D2.** Please complete the table below.

The Research Nurse can help you complete the medicine list.

<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
<i>Name of Pain Medicine</i>	<i>Dose of each pill/capsule</i>	<i>Total # of pills /capsules in last 24 hours</i>	<i>For what pain</i>
<i>Example: Extra strength Tylenol</i>	<i>500mg</i>	<i>6</i>	<i>Headache</i>
1			
2			
3			

**Thank you for completing the Pain Questionnaire**