TOMUS

F328

FOLLOW-UP PAIN QUESTIONNAIRE

Instructions: If you still have pain that you believe is due to your incontinence operation, we want to know about it.

For this Pain Questionnaire, we want you to tell us about only the pain you have had within the last 24 hours that you believe is due to your incontinence operation.

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.

If you have any questions, the Research Nurse can help you.

F328, version 03/27/06 (A)_rev01/09/07
Section A: General Study Information for Office Use Only

A1. ID#: Label

A2. Visit # F/U 2 weeks ..... TF2W; F/U 6 Weeks ..... TF6W; F/U 6 Months ..... TF06; F/U 12 Months .... TF12; F/U 24 Months .... TF24; Failure ..... TFAI

A3. Interviewer's ID: ____ ____ ____

A4. Date Patient Completed: ___ ___/___ ___ /___ ___ ___ ___ (Month / Day / Year)

A5. Coder's ID: ____ ____ ____

A6. Date Coded: ___ ___/___ ___ /___ ___ ___ ___ (Month / Day / Year)

A7. Form Version: English ..... 1 Spanish 2

Affix ID Label

Body Maps:

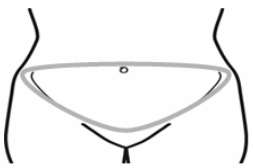
B0. Think back to this time yesterday. Have you had any pain **within the last 24 hours as a result of your incontinence operation?**

Yes..... 1 ➔ **Continue** No..... 2 ➔ **Skip to C1**

B1. Have you had **lower abdominal pain** in the last 24 hours because of your incontinence operation?

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. ➔



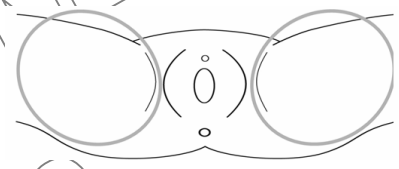
B1b. Rate the intensity of the **lower abdominal pain** by marking a vertical line through the pain scale below.

No Pain Sensation ***Most Intense Pain Sensation Imaginable***

B2. Have you had **inner thigh pain** in the last 24 hours because of your incontinence operation?

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 because of your incontinence operation?

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.

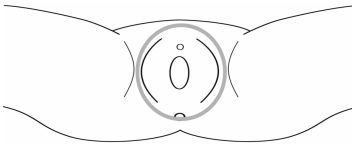
No Pain Sensation ***Most Intense Pain Sensation Imaginable***

Affix ID Label

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

Yes.....1 ➔ **COMPLETE B4a & B4b.** No.....2 ➔ **SKIP TO B5**

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



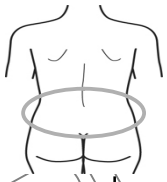
B4b. Rate the intensity of the pain **outside your vagina but inside the thigh crease** by marking a vertical line through the pain scale below.

No Pain Sensation ***Most Intense Pain Sensation Imaginable***

B5. Have you had **lower back pain** in the last 24 hours because of your incontinence operation?

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. ➔



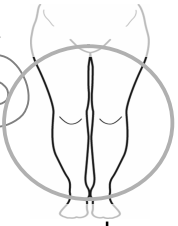
B5b. Rate the intensity of the **lower back pain** by marking a vertical line through the pain scale below.

No Pain Sensation ***Most Intense Pain Sensation Imaginable***

B6. Have you had **front leg pain** in the last 24 hours because of your incontinence operation?

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. ➔



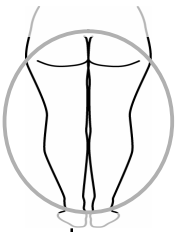
B6b. Rate the intensity of the **front leg pain** by marking a vertical line through the pain scale below.

No Pain Sensation ***Most Intense Pain Sensation Imaginable***

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

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***

Affix ID Label

Use of Pain Medication: Please write down all prescribed and over-the-counter pain medicines you took in the last 24 hours for pain you believe is due to your incontinence operation.

D1. Did you use pain medicines in the last 24 hours for pain due to your incontinence operation?

Yes.....1 ➔ **COMPLETE THE TABLE BELOW** No.....2 ➔ **GO TO END**

D2.	***A*** ***Name of Pain Medicine***	***B*** ***Dose of each pill/capsule***	***C*** ***Total # of pills /capsules in last 24 hours***	***D*** ***For what pain***
	Example: Tylenol 3	*500mg*	*3*	*Headache*
	1			
	2			
	3			

Thank you for completing the Pain Questionnaire