# Cholesterol Drugs and Muscle Questionnaire

**---These data will be used for research purposes only. Your personal information will not be released.---**

**Personal profile:**

**Last Name:_____ Today's Date:_____**
**First Name:_____ Date of Birth:_____**

## Part I. Cholesterol Drugs and Symptoms

***Please write neatly and clearly. Fill out as completely as possible.***

### A. FIRST CHOLESTEROL DRUG

1. **Name of first cholesterol drug: _____**
2. **Dose of first cholesterol drug: _____**
3. **Duration of use of first cholesterol drug: _____**
4. **Date of use of first cholesterol drug: _____**

5. **Please complete the following table (if known):**

| | Before this drug | On this drug |
|---|---|---|
| **Date of reading** | | |
| **Total cholesterol** (mg/dl) | | |
| **LDL** (mg/dl) | | |
| **HDL** (mg/dl) | | |
| **Triglycerides** (mg/dl) | | |
| **CPK** (IU/L) | | |

6. **Did you develop muscle/joint pains, weakness, or fatigability on this drug?**
   **Yes____ No____**

***If you answered no to the previous question, please skip to the next drug on page 3.***

7. **How long after starting the first drug did you *first notice any muscle symptoms*?**
   **_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
   **(number)**

8. **How long after starting this drug were the symptoms *at their worst*?**
   **_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
   **(number)**

**9. Please rate the severity of the symptoms *at their worst* by placing an "X" somewhere on the lines below. Check N/A (not applicable) if the symptom did not occur.**

| | Maximum Possible Worsening | No effect | Maximum Possible Improvement |
|---|---|---|---|
| **a. Pain:** ☐ **N/A** | \|---------- | ----------\| | ----------\| |
| **b. Weakness:** ☐ **N/A** | \|---------- | ----------\| | ----------\| |
| **c. Fatigue:** ☐ **N/A** | \|---------- | ----------\| | ----------\| |

**10. Did the symptoms get better with continued use of this drug?**
**Yes____ No____**

**11. Are you still taking the drug?**
**Yes____ No____**

***If you answered "yes" to the previous question, please go on to Part II on page 8.***

**12. Check one of the following:**

**a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?**

- ☐ **Without time off the first drug**
- ☐ **With time off the first drug, but before recovery was complete**
  - **Time off was:**

**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

***If you checked "12a", please go on to the next drug on page 3.***

**b. ☐ No improvement occurred after stopping this drug.**

**c. ☐ The problem got worse after stopping this drug.**

**d. ☐ Improvement occurred after stopping this drug**

***If you checked "12d", please complete #13. Otherwise, go on to #14.***

**13. How complete was your recovery? Check all that apply.**

**a. ☐ Complete recovery occurred. Recovery was complete after:**
**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**b. ☐ Improvement is ongoing now, after stopping this drug for:**
**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**c. ☐ Partial recovery occurred after stopping the drug for:**
**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**14. If you stopped taking this drug, please answer the following:**

**a. How long was it before you *first* noticed improvement in symptoms?**
**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**b. How long was it before *maximum* improvement in symptoms occurred?**
**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**15. Please rate the level of maximum recovery of your symptoms by placing an "X" on the lines below. Check N/A (not applicable) if the symptom did not occur.**

| | No improvement | Full recovery |
|---|---|---|
| **a. Pain:** ☐ **N/A** | \|---------- | ----------\| |
| **b. Weakness:** ☐ **N/A** | \|---------- | ----------\| |
| **c. Fatigue:** ☐ **N/A** | \|---------- | ----------\| |

**DID YOU TAKE ANOTHER DRUG OR CHANGE THE DOSAGE?**
**IF YES, PLEASE CONTINUE. IF NO, PLEASE MOVE ON TO PART II, PAGE 8.**

## B. SECOND CHOLESTEROL DRUG

**16. Name of second cholesterol drug: _____**
**17. Dose of second cholesterol drug: _____**
**18. Duration of use of second cholesterol drug: _____**
**19. Date of use of second cholesterol drug: _____**

**20. Please complete the following table (if known):**

| | Before this drug | On this drug |
|---|---|---|
| **Date of reading** | | |
| **Total cholesterol** (mg/dl) | | |
| **LDL** (mg/dl) | | |
| **HDL** (mg/dl) | | |
| **Triglycerides** (mg/dl) | | |
| **CPK** (IU/L) | | |

**21. Did you develop muscle/joint pains, weakness, or fatigability on this drug?**
**Yes____ No____**

***If you answered no to the previous question, please skip to the next drug on page 5.***

**22. How long after starting the second drug did you *first notice any muscle symptoms*?**
**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

 **Please go on to the next page ->**

**23. How long after starting this drug were the symptoms *at their worst*?**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**24. Please rate the severity of the symptoms *at their worst* by placing an "X" somewhere on the lines below. Check N/A (not applicable) if the symptom did not occur.**

| | Maximum Possible Worsening | No effect | Maximum Possible Improvement |
|---|---|---|---|
| **a. Pain:** | |---------- | ----------| |
| **☐ N/A** | | | |
| **b. Weakness:** | |---------- | ----------| |
| **☐ N/A** | | | |
| **c. Fatigue:** | |---------- | ----------| |
| **☐ N/A** | | | |

**25. Did the symptoms get better with continued use of this drug?**

**Yes____ No____**

**26. Are you still taking the drug?**

**Yes____ No____**

***If you answered "yes" to the previous question, please go on to Part II on page 8.***

**27. Check one of the following:**

**a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?**

- **☐ <u>Without time off</u> the first drug**
- **☐ <u>With time off</u> the first drug, but before recovery was complete**
  - **Time off was:**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

***If you checked "27a", please go on to the next drug on page 5.***

**b. ☐ No improvement occurred after stopping this drug.**

**c. ☐ The problem got worse after stopping this drug.**

**d. ☐ Improvement occurred after stopping this drug**

***If you checked "27d", please complete #28. Otherwise, go on to #29.***

**28. How complete was your recovery? Check all that apply.**

**a. ☐ Complete recovery occurred. Recovery was complete after:**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**b. ☐ Improvement is ongoing now, after stopping this drug for:**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**c. ☐ Partial recovery occurred after stopping this drug for:**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**29. If you stopped taking this drug, please answer the following:**

**a. How long was it before you *first* noticed improvement in symptoms?**
**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**b. How long was it before *maximum* improvement in symptoms occurred?**
**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**30. Please rate the level of maximum recovery of your symptoms by placing an "X" on the lines below. Check N/A (not applicable) if the symptom did not occur.**

| | **No improvement** | **Full recovery** |
|---|---|---|
| **a. Pain:** ☐ **N/A** | \|---------- | ----------\| |
| **b. Weakness:** ☐ **N/A** | \|---------- | ----------\| |
| **c. Fatigue:** ☐ **N/A** | \|---------- | ----------\| |

**DID YOU TAKE ANOTHER DRUG OR CHANGE THE DOSAGE?**
**IF YES, PLEASE CONTINUE. IF NO, PLEASE MOVE ON TO PART II, PAGE 8.**

## C. THIRD CHOLESTEROL DRUG

**31. Name of third cholesterol drug: _____**
**32. Dose of third cholesterol drug: _____**
**33. Duration of use of third cholesterol drug: _____**
**34. Date of use of third cholesterol drug: _____**

**35. Please complete the following table (if known):**

| | **Before this drug** | **On this drug** |
|---|---|---|
| **Date of reading** | | |
| **Total cholesterol** (mg/dl) | | |
| **LDL** (mg/dl) | | |
| **HDL** (mg/dl) | | |
| **Triglycerides** (mg/dl) | | |
| **CPK** (IU/L) | | |

**36. Did you develop muscle/joint pains, weakness, or fatigability on this drug?**
**Yes____ No____**

***If you answered "no"and you have no other choleterol drugs to report, please move on to Part II on page 8. If you answered "no" and have other cholesterol drugs to report, please contact the UCSD Statin Study for additional formatted sheets: (858) 558-4950 x215.***

**37. How long after starting the third drug did you *first notice any muscle symptoms*?**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**38. How long after starting this drug were the symptoms *at their worst*?**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**39. Please rate the severity of the symptoms at their worst by placing an "X" on the lines below. Check N/A (not applicable) if the symptom did not occur.**

| | Maximum Possible Worsening | No effect | Maximum Possible Improvement |
|---|---|---|---|
| **a. Pain:** ☐ **N/A** | \|---------- | ----------\|---------- | ----------\| |
| **b. Weakness:** ☐ **N/A** | \|---------- | ----------\|---------- | ----------\| |
| **c. Fatigue:** ☐ **N/A** | \|---------- | ----------\|---------- | ----------\| |

**40. Did the symptoms get better with continued use of this drug?**
**Yes____ No____**

**41. Are you still taking the drug?**
**Yes____ No____**

***If you answered "yes" to the prior question, please move on to Part II on page 8.***
***If you answered "no", but do not have other cholesterol-lowering drug(s) to report, please also move on to Part II on page 8.***
***If you answered "no" to the prior question and have other cholesterol-lowering drug(s) to report, please contact the UCSD Statin Study for additional sheets: (858) 558-4950 x215.***

**42. Check one of the following:**

**a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?**
- ☐ **<u>Without time off</u> the first drug**
- ☐ **<u>With time off</u> the first drug, but before recovery was complete**
  - **Time off was:**
    **_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
    **(number)**

***If you checked "42a", please call to request additional formatted sheets for additional drug/change of dosage from the UCSD Statin Study: (858) 558-4950 x215.***

**b. ☐ No improvement occurred after stopping this drug.**

**c. ☐ The problem got worse after stopping this drug.**

**d. ☐ Improvement occurred after stopping this drug**

***If you checked "42d", please complete #43. Otherwise, go on to #44.***

**43. How complete was your recovery? Check all that apply.**

**a. ☐ Complete recovery occurred. Recovery was complete after:**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**b. ☐ Improvement is ongoing now, after stopping this drug for:**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**c. ☐ Partial recovery occurred after stopping the drug for:**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**44. If you stopped taking this drug, please answer the following:**

**a. How long was it before you *first* noticed improvement in symptoms?**

**b. _____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**c. How long was it before *maximum* improvement in symptoms occurred?**
**_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**(number)**

**45. Please rate the level of maximum recovery of your symptoms by placing an "X" on the lines below. Check N/A (not applicable) if the symptom did not occur.**

**No improvement** **Full recovery**

**a. Pain:** |----------|
☐ **N/A**

**b. Weakness:** |----------|
☐ **N/A**

**c. Fatigue:** |----------|
☐ **N/A**

***If you stopped the third drug and have other cholesterol-lowering medication(s) to report, please request additional formatted sheets from the UCSD Statin Study: (858) 558-4950 x215.***

## Part II. Effects of Symptom(s) and Doctor's Response

***This part of the questionnaire will help us understand how these symptoms affect people's lives and how doctors respond to concerns about these symptoms.***

**1. Please mark the scale with an 'X' according to how much your symptom(s) affected your relationships or activities.**

| | Maximum Possible Worsening | No effect | Maximum Possible Improvement |
|---|---|---|---|
| **GENERAL** | | | |
| **a. Family functions:** (activity and relationship) | \|---------- | ----------\|---------- | ----------\| |
| **b. Social relations:** (activity and relationship) | \|---------- | ----------\|---------- | ----------\| |
| **c. Work function:** | \|---------- | ----------\|---------- | ----------\| |
| **d. Household function:** | \|---------- | ----------\|---------- | ----------\| |
| **e. Recreational activities:** | \|---------- | ----------\|---------- | ----------\| |
| **f. Emotional state/mood:** | \|---------- | ----------\|---------- | ----------\| |
| **g. Energy:** | \|---------- | ----------\|---------- | ----------\| |
| **h. Sleep:** (can refer to affects on quality, quantity, or restfulness of sleep) | \|---------- | ----------\|---------- | ----------\| |
| **i. Pain:** | \|---------- | ----------\|---------- | ----------\| |
| **j. Overall quality of life:** | \|---------- | ----------\|---------- | ----------\| |
| **SPECIFIC** | | | |
| **k. Raising arms over head:** | \|---------- | ----------\|---------- | ----------\| |
| **l. Rising from a chair:** | \|---------- | ----------\|---------- | ----------\| |
| **m. Climbing stairs:** | \|---------- | ----------\|---------- | ----------\| |
| **n. Sitting upright for prolonged periods:** | \|---------- | ----------\|---------- | ----------\| |
| **o. Walking:** | \|---------- | ----------\|---------- | ----------\| |
| **p. Running:** | \|---------- | ----------\|---------- | ----------\| |
| **q. Other: Specify: _____** | \|---------- | ----------\|---------- | ----------\| |



**Please go on to the next page ->**

2. **Did you or your doctor bring up the possibility of a link between your cholesterol drug use and muscle symptoms?**
   **Yes____ No____ If yes, who brought it up? You did____ Your doctor did____**
   **Comments:**

3. **If cholesterol drug use were discussed in relation to muscle symptoms, what was your doctor's approach to the possible link between cholesterol drug(s) and your symptoms?**
   **Endorsed/Supported_____ Dismissed_____ Was Neutral_____**

4. **Did your doctor fully appreciate the impact of symptom(s) on your well-being?**
   **Yes____ No____**
   **Comment/Explanation:**

5. **Were any tests done (x-rays, blood tests, others)?**
   **Yes____ No____**
   **Please describe:**

6. **Were any diagnoses given for you problems?**
   **Yes____ No____**
   **Please describe:**

7. **Were any treatments given?**
   **Yes____ No____**
   **Please describe:**

8. **Did you have any addition medical visits as a result of these problems?**
   **Yes____ No____**
   **Please describe:**

9. **Please record your most recent cholesterol levels in the table below (if known):**

| | **Date of record** | **Value (mg/dL)** |
|---|---|---|
| **Total cholesterol** (mg/dl) | | |
| **LDL** (mg/dl) | | |
| **HDL** (mg/dl) | | |
| **Triglycerides** (mg/dl) | | |
| **CPK** (IU/L) | | |

**10. Did you try any treatment such as other medicines, supplements or therapy to ease the pain?**

**Yes____ No____**

***If you answered "no" to the previous question, please skip #11.***

**11. If you tried treatments such as other medicines, supplements or therapy to ease the pain, please list the treatments below, place an "X" on the line to indicate how much the treatment helped, and comment on the effect. Please include dose and duration of treatment use.**

| Treatment (include dose and duration): | Maximum Possible Worsening | No effect | Maximum Possible Improvement | Comment on Effect |
|---|---|---|---|---|
| a. _____ | \|----------\| | | \|----------\| | _____ |
| b. _____ | \|----------\| | | \|----------\| | _____ |
| c. _____ | \|----------\| | | \|----------\| | _____ |
| d. _____ | \|----------\| | | \|----------\| | _____ |
| e. _____ | \|----------\| | | \|----------\| | _____ |
| f. _____ | \|----------\| | | \|----------\| | _____ |

## Part III. Muscle/Joint Pain

***Please Skip to Part IV on page 12 if you did not experience any muscle pain.***

**1. Please describe your pain while on cholesterol drugs.**

**2. For this symptom, please state the areas of your body where you felt the pain and characterize it as best you can (i.e. aching, burning, numbness, pins-and-needles, etc.) and describe how it affected you.**

**3. On a scale of 0 to 10, please use the scale below to rate how INTENSE your pain is. Place an "X on the line below to describe the instensity of your pain.**

**No Pain** |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **The most INTENSE pain sensation imaginable**

**0 1 2 3 4 5 6 7 8 9 10**



**Please go on to the next page ->**

**4. Although pain can have a low intensity, it may still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how unpleasant your pain feels by plancing an "X" on the line below.**

**Not Unpleasant** |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **The most UNPLEASANT sensation imaginable ("intolerable")**
**0 1 2 3 4 5 6 7 8 9 10**

**5. How long had you been taking cholesterol-lowering drugs when you *first noticed pain (or worsened pain if you normally have pain)*?**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**6. Did the pain (check one):**

- **☐ Get worse with continued use**
- **☐ Get better with continued use**
- **☐ Stay the same with continued use**

**Please describe:**

**7. How long after starting cholesterol-lowering drugs was the pain *at its worst*?**

**_____ (number)** **☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**Additional Comments:**

**8. Please place an "X" on the scale indicating your level of muscle pain *at its worst* before, during, and after you were on cholesterol-lowering drugs.**

| | **Worst pain** | **No pain** |
|---|---|---|
| **Before cholesterol drug use:** | \|---------- | ----------\| |
| **During cholesterol drug use:** | \|---------- | ----------\| |
| **After cholesterol drug use:** | \|---------- | ----------\| |

**9. Please place an "X" on the line below to indicate the percent of time you were in pain while you were *awake*..**

**0%** **50%** **100%**
|----------:----------|

 **Please go on to the next page ->**

**10. Did any other factors make the pain worse? (e.g. position, activities, time of day)**
**Yes___ No___**
**If yes, please describe:**

**11. Did any factors (besides treatment) seem to make the pain better? (e.g. position, activities, time of day)**
**Yes___ No___**
**If yes, please describe:**

## Part IV. Weakness

***Please Skip to Part V on page 13 if you did not experience any weakness.***

**1. Please describe your weakness while on statins.**

**2. For this symptom, please state the areas of your body where you felt the weakness and describe how it affected you.**

**3. How long had you been taking cholesterol-lowering drugs when you *first noticed weakness (or worsened weakness if you normally have weakness)*?**
**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**

**4. Did the pain (check one):**
- **☐ Get worse with continued use**
- **☐ Get better with continued use**
- **☐ Stay the same with continued use**

**Please describe:**

**5. How long after starting cholesterol-lowering drugs was the weakness *at its worst*?**
**_____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
**Additional Comments:**

6. **Please place an "X" on the scale indicating your level of weakness *at its worst* before, during, and after you were on cholesterol-lowering drugs.**

| | No Weakness | Complete Weakness |
|---|---|---|
| **Before cholesterol drug use:** | \|---------- | ----------\| |
| **During cholesterol drug use:** | \|---------- | ----------\| |
| **After cholesterol drug use:** | \|---------- | ----------\| |

7. **How constant was the weakness? (i.e. all the time, at night only, lasted a few minutes then went away, etc.)**

8. **Did any other factors make the weakness worse? (e.g. position, activity, time of day)**
   **Yes___ No___**
   **If yes, please describe:**

9. **Did any other factors (besides treatment) seem to make the weakness better? (e.g. rest, position, time of day)**
   **Yes___ No___**
   **If yes, please describe:**

## Part V. Fatigue

***Please Skip to Part VI on page 15 if you did not experience any fatigue.***

1. **Please describe your fatigue.**

2. **For this symptom, the areas of your body where you felt the fatigue were:**
   - ☐ **Not localized**
   - ☐ **Greater in certain areas (please specify which areas and describe)**

3. **How long had you been taking cholesterol-lowering drugs when you *first felt fatigue*?**
   **_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
   **(number)**

 **Please go on to the next page ->**

4. **Did the fatigue:**
   - ☐ **Get worse with continued use**
   - ☐ **Get better with continued use**
   - ☐ **Stay the same with continued use**

   **Please describe:**

5. **How long after starting cholesterol-lowering drugs was the fatigue *at its worst*?**
   **_____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
   **(number)**

6. **Please place an "X" on the scale indicating your level of fatigue *at its worst* before, during, and after you were on cholesterol-lowering drugs.**

| | **Complete fatigue** | **No fatigue** |
|---|---|---|
| **Before cholesterol drug use:** | \|---------- | ----------\| |
| **During cholesterol drug use:** | \|---------- | ----------\| |
| **After cholesterol drug use:** | \|---------- | ----------\| |

7. **Please place an "X" on the line below to indicate the percent of time you were fatigued while you were *awake*.**

**0%** **100%**
|----------:----------|

8. **Did any other factors increased your fatigue? (e.g. position, activities, time of day)**
   **Yes___ No___**
   **If yes, please describe:**

9. **Did any factors (besides treatment) seem to alleviate your fatigue? (e.g. position, activities, time of day)**
   **Yes___ No___**
   **If yes, please describe:**

 **Please go on to the next page ->**

## Part VI. Additional Comments

***This part of the questionnaire offers the option to add any additional comments that concern your experience or how your experience has affected you. Include <u>any</u> detail you think may be relevant. We are interested in all you would like to share with us. Please use the backside for additional space or to attach additional pages if needed. We sincerely thank you for your time and effort.***

**Please send this questionnaire and the consent form to:**
**University of California, San Diego**
**Statin Study**
**9500 Gilman Drive 0995**
**La Jolla, CA 92093-0995**



**End. Thank you.**

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

# Brief Pain Inventory (Short Form)

Date: _____/_____ /_____ Time: _____

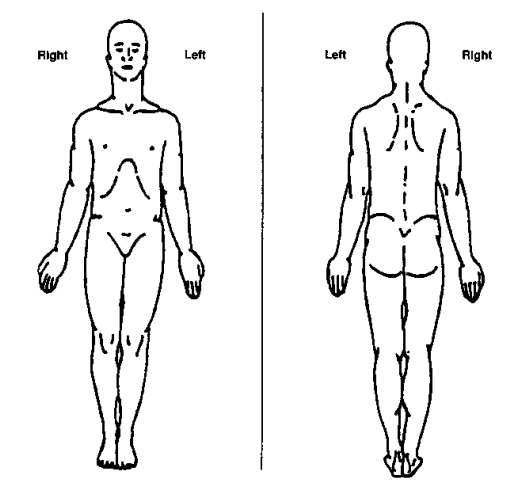
Name: _____ _____ _____

Last First Middlle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.




3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

4. Please rate your pain by circling the one nuimber that best describes your pain at its least in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

5. Please rate your pain by circling the one number that best describes your pain on the average.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

6. Please rate your pain by circling the one number that tells how much pain you have right now.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
|---|---|---|---|---|---|---|---|---|---|---|
| No Relief | | | | | | | | | | Complete Relief |

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

B. Mood

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

C. Walking Ability

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

D. Normal Work (includes both work outside the home and housework)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

E. Relations with other people

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

F. Sleep

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |

G. Enjoyment of life

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does not Interfere | | | | | | | | | | Completely Interferes |