Orthopaedic Associates of Muskegon
West Michigan Spine Center
Grand Haven Bone & Joint

www.oamkg.com
www.wmspinecenter.com
www.ghboneandjoint.com

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Patient Pain Log

Name: ____________________ DOB: ____________ Date: ____________
Diagnosis: ____________________
Procedure: ____________________ End Time: ____________
Sedation Meds/Recovery Room: ____________________
Referring Physician: ____________________

Pain Rating BEFORE the Procedure

0 = No pain at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 10 = Pain as bad as it can be

Pain Rating AFTER the Procedure

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

For MBB, please rate pain every 15 minutes for the first 45 minutes, then rate hourly:

Minutes	Avg. Pain Rating 0-10	Pain Medications
15		
30		
45		

Hour/Time	Avg. Pain Rating 0-10	Pain Medications
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 the procedure:

Day	Avg. Pain Rating 0-10	Pain Medications
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

Please return this form at your next office visit. Please keep a copy for yourself. Your feedback is required. We need your input to determine if we do further blocks and plan other aspects of your care.

FOR OFFICE USE ONLY: Physician Comment Section

☐ Negative "–" or No response ☐ Equivocal +/– ☐ Positive "+" or Good response
☐ No Comment ☐ See Referring MD for follow up ☐ See Pain Clinic

Future Treatment Plan: ____________________

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MD Signature: ____________________ Date:: ____________ Time: ____________