Code number:

APS Patient Outcome Questionnaire (APS-POQ-R)

The following questions are about pain you experienced during the first 24 hours in the hospital or after your operation.

1. On this scale, please indicate the **least** pain you had in the first 24 hours:

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

no pain — worst pain possible

2. On this scale, please indicate the **worst** pain you had in the first 24 hours:

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

no pain — worst pain possible

3. On this scale, please indicate the **average** pain you had in the first 24 hours:

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

no pain — worst pain possible

4. How often were you in **severe** pain in the first 24 hours? Please mark your best estimate of the percentage of time you experienced severe pain:

○ 0% ○ 10% ○ 20% ○ 30% ○ 40% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100%

Never in severe pain — Always in severe pain

5. Mark the one number below that best describes how much pain **interfered or prevented you from**:

a. Doing activities in bed such as turning, sitting up, repositioning.

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

Does not interfere — Completely interferes

b. Doing activities out of bed such as walking, sitting in a chair, standing at the sink.

○ **On bedrest**

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

Does not interfere — Completely interferes

c. Falling asleep

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

Does not interfere — Completely interferes

d. Staying asleep

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

Does not interfere — Completely interferes

6. Pain can affect our mood and emotions. On this scale, please circle the one number that best **shows how much the pain caused you to feel**:

a. Anxious ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not at all — Extremely

b. Depressed ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not at all — Extremely

c. Frightened ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not at all — Extremely

d. Helpless ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not at all — Extremely

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7. Have you had any of the following **side effects**? Please mark "0" if no; if yes, please circle the one number that best shows the severity of each:

a. Nausea	○ 0 None	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 Severe
b. Drowsiness	○ 0 None	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 Severe
c. Itching	○ 0 None	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 Severe
d. Dizziness	○ 0 None	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10 Severe

8. In the first 24 hours, how much pain **relief** have you received? Please circle the one percentage that best shows how much relief you have received from all of your pain treatments combined (medicine and non-medicine treatments):

○ 0% ○ 10% ○ 20% ○ 30% ○ 40% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100%

No Relief — Complete Relief

9. Were you **allowed to participate in decisions** about your pain treatment as much as you wanted to?

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

Not at all — Very much so

10. Mark the one number that best shows how **satisfied** you are with the results of your pain treatment while in the hospital:

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

Extremely Dissatisfied — Extremely Satisfied

11. Did you receive any **information** about your pain treatment options? ○ No ○ Yes
    a. If yes, please mark the number that best shows how helpful the information was:

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

Not at all helpful — Extremely helpful

12. Did you use any **non-medicine methods** to relieve your pain? ○ No ○ Yes
    a. If yes, **mark all** that apply:

○ cold pack ○ meditation ○ deep breathing

○ listen to music ○ distraction (such as watching TV, reading)

○ prayer ○ heat ○ relaxation

○ imagery or visualization ○ walking ○ massage

○ other (please describe)

13. How often did a nurse or doctor **encourage you to use** non-medicine methods?

○ Never ○ Sometimes ○ Often

Thank you for your time and feedback