Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

RADIOLOGY POST INJECTION PAIN ASSESSMENT – PAIN DIARY

Date: _____

During business hours call (608) 263-9729. After hours call (608) 262-2122 and ask for the bone radiologist on call

Name of Procedure:	
Radiologist:	
Ordering Physician:	
Medication Used:	
Accession #:	

Following the procedure, you should resume your normal activity. You will need to keep a record of any change in your symptoms for 2 weeks. Please circle the number which best describes your pain in the table below.

PAIN RECORD

Circle the number that best describes your pain: 0 being no pain, 10 being the worst pain imaginable

Date	**Pain Assessment**										
	No Pain										**Worst Pain**
Prior to Procedure	0	1	2	3	4	5	6	7	8	9	10
Immediately after Procedure	0	1	2	3	4	5	6	7	8	9	10
Evening of injection	0	1	2	3	4	5	6	7	8	9	10
1st day after injection	0	1	2	3	4	5	6	7	8	9	10
2nd Day	0	1	2	3	4	5	6	7	8	9	10
3rd Day	0	1	2	3	4	5	6	7	8	9	10
7th Day	0	1	2	3	4	5	6	7	8	9	10
14th Day	0	1	2	3	4	5	6	7	8	9	10

Please note any side-effects, problems, or comments: _____

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After you have completed this questionnaire, please return the form in the envelope provided.

IF RECEIVED RETURN TO:
UW Health at The American Center
4602 Eastpark Blvd, Room 1053, Mail Code AC03
Madison, WI 53718-2002