PATIENT PAIN AND FATIGUE SELF ASSESSMENT

Patient Name: _____ DOB: _____
Last First Maiden/Middle

Attending Physician: _____

Pain

Location(s) of pain: _____

_____

Characteristics of pain: (please check all that apply)

☐Burning ☐Sharp ☐Dull ☐Muscle ☐Bone ☐Other: _____

Severity of pain 0-10: (0= no pain; 10= extreme pain) _____

What treatments or medications are you using for your pain? _____

Is the pain controlled with meds? ☐ yes ☐ no Please explain: _____

_____

In the past 24 hours, how much relief have pain treatments and /or medications provided?
(check the most accurate percentage)

☐0% ☐25% ☐50% ☐75% ☐100%

Does your pain interfere with: (check all that apply) ☐Daily Activities ☐Mood

☐Ability to Work ☐Relationships ☐Sleep ☐Ability to enjoy life

☐ Normal work responsibilities (both in-home & outside employment)

Are you currently experiencing pain? ☐Yes ☐No

Fatigue

How would you rate your fatigue on a scale of 0-10 over the past 7 days? _____
(0 = no fatigue 10 = worst fatigue you can imagine)

For Texas Oncology use only

Attending Nurse: _____ Signature: _____

Date reviewed: _____

Please return completed form to the appropriate physician's office.