

PREOPERATIVE ASSESSMENT

1. How many tablets of prescription opioid pain medication did you take in the past 30 days?

0
 1 to 2
 3 to 4
 5 to 10
 11 to 15
 16 to 30
 30 or more

2. Please respond to each item by marking one box per row:

<u>In the past 7 days...</u>	<u>Had no pain</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Very Severe</u>
How intense was your pain at its worst?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How intense was your average pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
What is your level of pain right now?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

3. For the following statements, please circle the number that is most appropriate for you :

	<i>Strongly Disagree</i>	<i>Moderately Disagree</i>	<i>Slightly Disagree</i>	<i>Slightly Agree</i>	<i>Moderately Agree</i>	<i>Strongly Agree</i>
1. My abdominal wall has a huge impact on my health	1	2	3	4	5	6
2. My abdominal wall causes me physical pain	1	2	3	4	5	6
3. My abdominal wall interferes when I perform strenuous activities, e.g. heavy lifting	1	2	3	4	5	6
4. My abdominal wall interferes when I perform moderate activities, e.g. bowling, bending over	1	2	3	4	5	6
5. My abdominal wall interferes when I walk or climb stairs	1	2	3	4	5	6
6. My abdominal wall interferes when I dress myself, take showers, and cook	1	2	3	4	5	6
7. My abdominal wall interferes with my sexual activity	1	2	3	4	5	6
8. I often stay at home because of my abdominal wall	1	2	3	4	5	6
9. I accomplish less at home because of my abdominal wall	1	2	3	4	5	6
10. I accomplish less at work because of my abdominal wall	1	2	3	4	5	6
11. My abdominal wall affects how I feel every day	1	2	3	4	5	6
12. I often feel blue because of my abdominal wall	1	2	3	4	5	6

Please answer all of the 9 following questions in the 3 main fields of:

1. Pain of the side of the hernia
2. Restrictions of activities because of pain or discomfort
3. Cosmetic discomfort

Therefore, please mark a number corresponding to your current state.

Respectively, you will give a 0 (no pain, no restriction and cosmetically beautiful) for the best conditions and a 10 for the worst state (worst pain, completely restricted and cosmetically ugly). If you do not perform one of these asked activities, please mark the X in the last column.

1. Pain at the site of the hernia												
	0 = no pain					10 = worst pain imaginable						
Pain in rest (lying down)	0	1	2	3	4	5	6	7	8	9	10	
Pain during activities (walking, biking, sports)	0	1	2	3	4	5	6	7	8	9	10	
Pain felt during the last week	0	1	2	3	4	5	6	7	8	9	10	
2. Restrictions of activities because of pain or discomfort at the site of the hernia												
	0 = no restriction					10 = completely restricted						
Restriction from daily activities (inside the house)	0	1	2	3	4	5	6	7	8	9	10	X
Restriction outside the house (walking, biking, driving)	0	1	2	3	4	5	6	7	8	9	10	X
Restriction during sports	0	1	2	3	4	5	6	7	8	9	10	X
Restriction during heavy labour	0	1	2	3	4	5	6	7	8	9	10	X
	X = If you do not perform this activity											
3. Cosmetic discomfort												
	0 = very beautiful					10 = extremely ugly						
Shape of your abdomen	0	1	2	3	4	5	6	7	8	9	10	
Site of the hernia	0	1	2	3	4	5	6	7	8	9	10	