ACHQC
ABDOMINAL CORE HEALTH QUALITY COLLABORATIVE

VENTRAL & INGUINAL POSTOPERATIVE 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** ☐ **31 or more**

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

In the past 7 days…

How intense was your pain at its worst?	**Had no pain**	**Mild**	**Moderate**	**Severe**	**Very Severe**
How intense was your average pain?	**Had no pain**	**Mild**	**Moderate**	**Severe**	**Very Severe**
What is your level of pain right now?	**Had no pain**	**Mild**	**Moderate**	**Severe**	**Very Severe**

3. Regarding your hernia operation:

Do you feel your hernia has come back?	☐ **Yes** ☐ **No**
Do you feel or see a bulge?	☐ **Yes** ☐ **No**
Do you have physical pain or symptoms at the site	☐ **Yes** ☐ **No**
Have you had additional surgery since your hernia operation?	☐ **Yes** ☐ **No** *If Yes, reason for additional surgery:* ☐ **For Hernia** ☐ **For another reason**

4. Please circle a response corresponding to your current state.
Respectively, you will give a 0 for the best conditions (no pain, no restriction and cosmetically beautiful) 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 select the X option.

Pain at the site of the hernia

Pain in rest (lying down)	**No pain 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Worst pain imaginable 10**
Pain during activities (walking, biking, sports)	**No pain 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Worst pain imaginable 10**
Pain felt during the last week	**No pain 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Worst pain imaginable 10**

Restrictions of activities because of pain or discomfort at the site of the hernia												
Restriction from daily activities (inside the house)	**No restriction 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Completely restricted 10**	**X**
Restrictions during activities (walking, biking, sports)	**No restriction 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Completely restricted 10**	**X**
Restrictions during sports	**No restriction 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Completely restricted 10**	**X**
Restrictions during heavy labour	**No restriction 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Completely restricted 10**	**X**

Cosmetic discomfort											
Shape of your abdomen	**Very beautiful 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Extremely ugly 10**
Site of the hernia	**Very beautiful 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Extremely ugly 10**

Used with permission from the European Registry of Abdominal Wall Hernias (EuraHS)

5. For the following statements, please circle the number that is most appropriate for you.	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
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

6. Decision Regret Scale

Please think about the decision you made about abdominal surgery after talking to your health professional.
Please show how you feel about these statements by selecting a choice from **Strongly Agree** to **Strongly Disagree.**

It was the right decision	**Strongly Agree 1**	**Agree 2**	**Neither Agree Nor Disagree 3**	**Disagree 4**	**Strongly Disagree 5**
I regret the choice that was made	**Strongly Agree 1**	**Agree 2**	**Neither Agree Nor Disagree 3**	**Disagree 4**	**Strongly Disagree 5**
I would go for the same choice if I had to do it over again	**Strongly Agree 1**	**Agree 2**	**Neither Agree Nor Disagree 3**	**Disagree 4**	**Strongly Disagree 5**
The choice did me a lot of harm	**Strongly Agree 1**	**Agree 2**	**Neither Agree Nor Disagree 3**	**Disagree 4**	**Strongly Disagree 5**
The decision was a wise one	**Strongly Agree 1**	**Agree 2**	**Neither Agree Nor Disagree 3**	**Disagree 4**	**Strongly Disagree 5**

Decision Regret Scale © AM O'Connor 1996