Evaluation of pain levels and pain management in patients after elective total knee replacement surgery

Supplement: Revised American Pain Society 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 How often were you in severe pain in the first 24 hours? Please circle 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

4 Circle 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.

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

5	**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
6	**Have you had any of the following side effects? Please circle '0' if now; if yes. please circle the one number that best shows the severity of each.**										
a	**Nausea**										
	0	1	2	3	4	5	6	7	8	9	10
	none										severe
b	**Drowsiness**										
	0	1	2	3	4	5	6	7	8	9	10
	none										severe
c	**Itching**										
	0	1	2	3	4	5	6	7	8	9	10
	none										severe
d	**Dizziness**										
	0	1	2	3	4	5	6	7	8	9	10
	none										severe

7 **In the first 24 hours. how much pain relief did you receive? 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 1 2 3 4 5 6 7 8 9 10

no relief — complete relief

8 **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

9 **Circle 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

10 **Did you receive any information about your pain treatment options?** ☐ **No.** ☐ **Yes.**

a **If yes. please circle 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

11 **Did you use any non-medicine methods to relieve your pain?** ☐ **No.** ☐ **Yes.**

If yes. please check all that apply:

- ☐ cold pack
- ☐ deep breathing
- ☐ distraction (Such as watching TV. reading)
- ☐ heat
- ☐ other (please describe)
- ☐ imagery or visualisation
- ☐ massage
- ☐ meditation
- ☐ listen to music
- ☐ prayer
- ☐ relaxation
- ☐ walking

12 **How often did a nurse or doctor encourage you to use non-medication methods?**

☐ never ☐ sometimes ☐ often