

Appendix A

Demographic data sheet (to be filled by patients)

Age: ____

Gender

- Male
- Female

Marital status:

- Single
- Married
- Separated
- Divorced
- Widowed

Education level:

- Illiterate
- Read and Write
- Elementary
- Intermediate
- Secondary
- Technical
- University

Country of residence: _____

Place of residence (County): _____

Place of residence:

- Urban
- Rural

Religion:

- Christianity
 - Orthodox
 - Maronite
 - Catholic
 - Armenian
- Islam
 - Shia
 - Sunni
- Druze

What type of healthcare insurance do you have?

1. Private insurance
2. Lebanese National Social Security Fund
3. Ministry of Health
4. Self-pay
5. Private insurance + Lebanese National Social Security Fund
6. Private insurance + Ministry of Health
7. Private insurance + Self pay
8. Lebanese National Social Security Fund + Ministry of Health
9. Lebanese National Social Security Fund + Self pay
10. Ministry of Health + Self pay
11. Others

Have you felt pain different than the previous ones at least during the last month?

- Yes
- No

Appendix B

Brief Pain Inventory (BPI)
(to be filled by patients)

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)


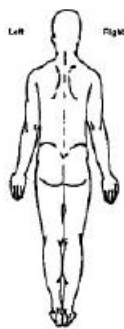
Date: ____/____/____ Time: _____

Name: _____
 Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

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Pain Experience (to be filled by patients)

Onset of pain: _____

Duration of pain: _____

Pain medications prescribed: _____

Adherence to pain medications: _____

Has pain resolved:

- Yes
 - Degree of resolution:
 - A. Mild
 - B. Moderate
 - C. Complete
- No

Thank you for your participation

Appendix C

Clinical data sheet

(to be filled by the research fellow through access to health records)

Please answer the following statements:

Date of diagnosis: _____

Cancer site: _____

Cancer stage:

- Stage 1
- Stage 2
- Stage 3
- Stage 4

Metastatic site if applicable: _____

Status of treatment

- None
- Current
- Past

Surgery: _____

Chemotherapy:

- Regimen: _____
- Duration: _____

Radiation therapy:

- Yes
 - Duration: _____
- No

Other types of therapy: _____

Pain assessment documentation:

- Yes
 - Frequency: _____
- No

Pain medications: _____