Plastic Surgery Post-Operative Pain Questionnaire

- How satisfied were you with your postoperative pain control?
  (On a scale of 0 to 10, 0 being not controlled at all and 10 being completely controlled)

  0------1------2------3------4------5------6------7------8------9------10

- What medications did you take at home after your surgery for pain?

  1. Ibuprofen/Aleve/Advil/Motrin **Yes** **No** How many days did you take this? ________
  2. Tylenol **Yes** **No** How many days did you take this? ________
  3. Gabapentin/Neurontin **Yes** **No** How many days did you take this? ________
  4. Toradol (Ketorolac) **Yes** **No** How many days did you take this? ________
  5. Tramadol **Yes** **No** How many days did you take this? ________
  6. Flexeril or Valium **Yes** **No** How many days did you take this? ________
  7. Oxycodone/Hydrocodone Vicodin/Percocet/Norco **Yes** **No** How many days did you take this? ________

- How satisfied were you with communication from your doctor's office about the purpose of each of these medications?
  (On a scale of 0 to 10, 0 being not satisfied at all and 10 being completely satisfied)

  0------1------2------3------4------5------6------7------8------9------10

- How many opioid (Oxycodone/Hydrocodone/Vicodin/Percocet/Norco) pills did you take? _____
- How many do you have left over? _______
- Are you still taking opioid pain medication? **Yes** **No**
- Did you have to call the office or ask your doctor for a refill of opioid pain medication?

  Yes **No**
- Did you have to go to an ER, urgent care or other doctor for a refill of opioid pain medication?

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Yes **No**

- Where did you store your opioid pain medication?
  a) Bedside table
  b) Bathroom or kitchen cabinet
  c) Other: ______________________________

- Was the storage location locked? **Yes** **No**

- How did you dispose of your left over pain medication?
  a) I haven't disposed of it yet
  b) Trash can
  c) Flushed it
  d) Brought it back to a designated disposal or medication return site
  e) I didn't have any left over
  f) Other: ____

- Did you take opioid pain medication **before** your most recent surgery? **Yes** **No**

  If yes: What medication did you take? _________________________

  What dose? ______________ How often? ________________

End of Survey

Office Use:

Surgery Date: ___________________

Today's Date: ___________________

Procedure(s):