

Self-complete questionnaire for surgical patients

This questionnaire encompasses 31 questions concerning your last operation for trigeminal neuralgia and will be used by your doctor at the Danish Headache Center to see if you have benefited from the operation. Please bring the completed questionnaire with you on your next visit to the Danish Headache Center.

Thank you in advance for taking your time to complete the questionnaire.

Patient name:.....
Name and date of birth:.....

Date of completion of questionnaire:.....
Date of operation:.....

Please circle the most appropriate answer.

This section is concerning your pain and whether you have experienced pain since your last operation.

1.	Have you had TN pain since your last operation?	No <input type="checkbox"/> (go to Q12)	Yes <input type="checkbox"/>
2a.	The pain you feel now, is that the same as before the surgery?	No <input type="checkbox"/>	Yes <input type="checkbox"/> Do not know <input type="checkbox"/>
2b.	If the pain does not feel the same way as before the surgery, how does the pain feel different?	<input type="checkbox"/> Still paroxysmal stabbing pain, but less intensive <input type="checkbox"/> Still paroxysmal stabbing pain, but more intensive <input type="checkbox"/> Constant/boring <input type="checkbox"/> Other, please describe:.....	
3.	When did you experience pain again after your surgery?	<input type="checkbox"/> Immediately <input type="checkbox"/> 1-6 months after the surgery <input type="checkbox"/> 7-12 months after the surgery <input type="checkbox"/> 1-2 years after the surgery	
4.	Is the pain present all the time?	<input type="checkbox"/> No <input type="checkbox"/> Yes (go to Q7)	
5.	If the pain is not there all the time, but comes and goes, how long does a pain attack lasts?	<input type="checkbox"/> Seconds <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	
6.	How long does it usually take between the bouts of pain?	<input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks	
7.	What is the pain intensity?	0 1 2 3 4 5 6 7 8 9 10 No pain Worst imaginable pain	
8.	Where is the pain localized?	<input type="checkbox"/> in the same area as before the surgery <input type="checkbox"/> in another area than before the surgery	
9.	What can trigger the pain?	<input type="checkbox"/> Touch <input type="checkbox"/> Talking <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Eating <input type="checkbox"/> Cold wind <input type="checkbox"/> Chewing <input type="checkbox"/> Other, please describe:.....	
10.	Have you taken TN medication for your pain?	<input type="checkbox"/> No (go to Q12) <input type="checkbox"/> Daily use <input type="checkbox"/> Sometimes	
11.	What TN medication do you take for your TN pain?	Name of the medicine:..... Dosage pr. day in mg:.....	

This section is about whether you have experienced any complications after your last surgery for trigeminal neuralgia

12a	If you had any hypoesthesia before the surgery, has the surgery then changed it?	<input type="checkbox"/> I have never experienced hypoesthesia <input type="checkbox"/> Yes, and it is worse than before <input type="checkbox"/> Yes, but its better now than before <input type="checkbox"/> Yes, but it is unchanged	
12b	Have you after the surgery experienced less hypoesthesia in an area where you have experienced hypoesthesia before the surgery?	<input type="checkbox"/> No (go to Q17) <input type="checkbox"/> Yes	
13	If you answered yes in Q12b how long time after the operation did you experience hypoesthesia?	<input type="checkbox"/> Immediately <input type="checkbox"/> 1-2 months after the surgery <input type="checkbox"/> 3-5 months after the surgery <input type="checkbox"/> 6 months or more after the surgery	
14	How severe is the hypoesthesia? (compared to for instance anaesthesia at the dentist)	<input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Severe	
15	How painful is it to touch the area with hypoesthesia?	<input type="checkbox"/> No pain <input type="checkbox"/> Mild pain <input type="checkbox"/> Severe pain	
16	Have you experienced a burning pain or a different sensation in the face ipsilateral to the side of operation?	<input type="checkbox"/> Not at all <input type="checkbox"/> Mild <input type="checkbox"/> Severe	
17	Have you experienced impaired hearing after the operation?	<input type="checkbox"/> Not at all <input type="checkbox"/> Mild <input type="checkbox"/> Severe	
18	If yes, has this impaired hearing changed in some way?	<input type="checkbox"/> It lasted less than 6 months – but it is now back to normal <input type="checkbox"/> It lasted more than 6 months – but it is now back to normal	

	<input type="checkbox"/> It is unchanged <input type="checkbox"/> The hearing impairment is still there but it has improved. <input type="checkbox"/> The hearing impairment is worse																																			
19	Do you feel unsecure when walking after your latest operation? <input type="checkbox"/> No <input type="checkbox"/> Yes																																			
20	Do you feel dizzy now than before you latest surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes																																			
21	Do you have more headache than usual after your latest surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes																																			
22	Have you after the operation had eating difficulties which you have not experienced before? <input type="checkbox"/> No <input type="checkbox"/> Yes																																			
23	Have you had vision problems after the operation which you have not experienced before? <input type="checkbox"/> No <input type="checkbox"/> Yes																																			
24	Have you experienced any complications after the operation which is not mentioned above? If yes, please describe:.....																																			
25	Please describe how the complications affect your quality of life? <table border="0"> <tr> <td>Numbness:</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Burning sensation/changed sensation</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Dizziness</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Headache</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Eating difficulties</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Vision problems</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> <tr> <td>Other complications, please describe:.....</td> <td>Not at all</td> <td>Slightly</td> <td>Moderately</td> <td>Pronounced</td> </tr> </table>	Numbness:	Not at all	Slightly	Moderately	Pronounced	Burning sensation/changed sensation	Not at all	Slightly	Moderately	Pronounced	Dizziness	Not at all	Slightly	Moderately	Pronounced	Headache	Not at all	Slightly	Moderately	Pronounced	Eating difficulties	Not at all	Slightly	Moderately	Pronounced	Vision problems	Not at all	Slightly	Moderately	Pronounced	Other complications, please describe:.....	Not at all	Slightly	Moderately	Pronounced
Numbness:	Not at all	Slightly	Moderately	Pronounced																																
Burning sensation/changed sensation	Not at all	Slightly	Moderately	Pronounced																																
Dizziness	Not at all	Slightly	Moderately	Pronounced																																
Headache	Not at all	Slightly	Moderately	Pronounced																																
Eating difficulties	Not at all	Slightly	Moderately	Pronounced																																
Vision problems	Not at all	Slightly	Moderately	Pronounced																																
Other complications, please describe:.....	Not at all	Slightly	Moderately	Pronounced																																

The last section is about how your general view on the surgery and your patient satisfaction.

26.	When you look back, do you think that the time of surgery was correct? <input type="checkbox"/> The surgery was done at the correct time <input type="checkbox"/> The surgery should have been done earlier <input type="checkbox"/> The surgery should have been done later <input type="checkbox"/> The surgery should never have been performed.																
27.																	
28.	Do you experience that the TN pain restrain you in your activities with respect to your leisure time, work and/or education? <table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>Not relevant</td> </tr> <tr> <td>a. Work</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Education</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Leisure time</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Yes	No	Not relevant	a. Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Not relevant														
a. Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
b. Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
c. Leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>														
29.	Have you during the last month felt down or depressed? <input type="checkbox"/> No <input type="checkbox"/> Yes																
30.	Have you during the last month experienced reduced desire or interest in doing things you would normally want to do or feel interest in? <input type="checkbox"/> No <input type="checkbox"/> Yes																
31.	Would you recommend this surgery to others? <input type="checkbox"/> No <input type="checkbox"/> Yes																

THANK YOU - for completing the questionnaire.

If you have any further comments, feel free to write them on the back of this questionnaire.