Pain management diary

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Use this form to keep a record of your pain levels and times. You can print the form and complete it at your leisure. In the form, record the day, date, and time you took a medication, and which medication and how much of it you took. In the "Pain before" and "Pain after" columns, rate the pain on a scale of 0 to 10 (from 0 = no pain to 10 = worst pain ever). Under "Time to relief," note about how long it took for the medication to be effective. Below the form, list any side effects of the medication and questions for your health care provider in the space provided.

NAME:	
DATE:	

DAY	DATE	TIME	MEDICATION/DOSE	PAIN BEFORE (0-10)	TIME OF RELIEF	PAIN AFTER
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

SIDE EFFECTS:	
QUESTIONS FOR YOUR DOCTOR OR NURSE:	