Daily Pain Diary

Date _____Type of Pain Scale Used _____
(ie: 0-10, Faces etc.)

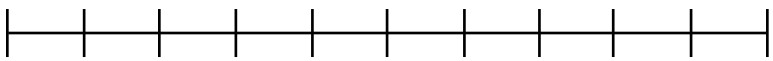
Time	Medication Taken	Dose	Pain	Comments

Side Effects:

	none	mild	moderate	severe
Nausea	0	1	2	3
Vomiting	0	1	2	3
Sedation	0	1	2	3

Bowel Movements _____Character: _____hard _____soft _____loose

Overall satisfaction with pain control:

Not Satisfied  Very Satisfied

0 1 2 3 4 5 6 7 8 9 10

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