

**Pain Journal**

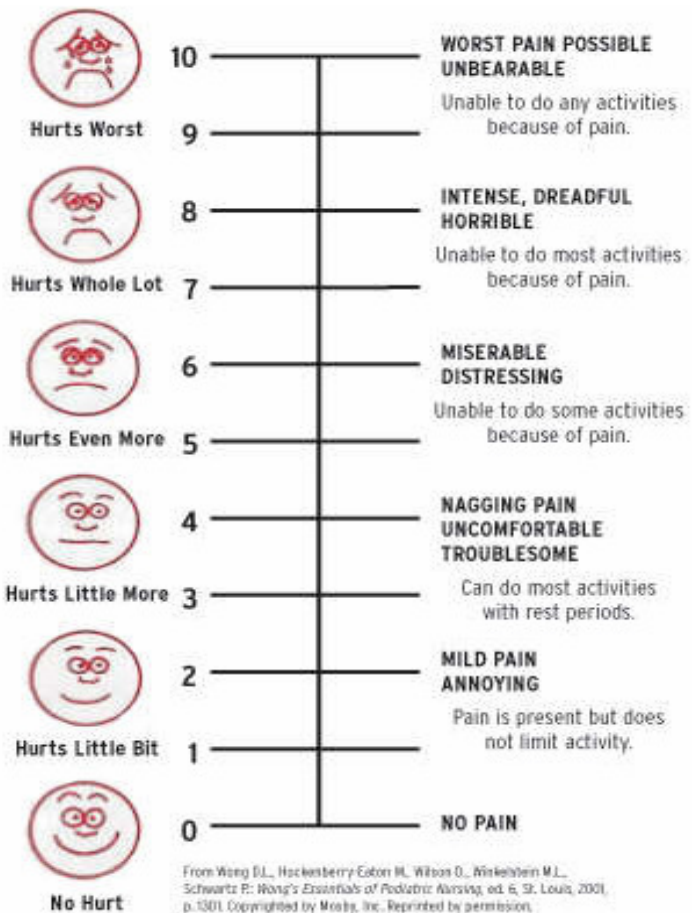
**Name:** \_\_\_\_\_ **MRN:** \_\_\_\_\_

**Procedure Date:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Procedure performed:** \_\_\_\_\_

TIME	Pain level (1-10 scale)	Comments
Pre-Procedure		
Post-Procedure		
1 hr		
2 hrs		
3 hrs		
6 hrs		
8 hrs		
12 hrs		
24 hrs		
3 days		
1 week		
2 wks		
3 wks		
4 wks		

**Pain Level Reference**



**\*Please complete this form and bring it to your next visit.**