

Personal Pain Assessment

 **FENTORA**[®]
fentanyl buccal tablet @



Questions about persistent pain

- Do you have persistent pain? Yes No If yes, where?

- Have you had persistent pain since your last visit? Yes No
If yes, where? _____
- Using the faces scale at the top of the page, please circle the number below that describes the intensity of your persistent pain. If you have more than 1 kind of persistent pain, circle up to 2 numbers. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
- How would you best describe your persistent pain? (Please check all boxes that apply)
 Aching Burning Dull Numb Sharp Shooting Stabbing Throbbing
 Tingling Other _____
- Are you taking an around-the-clock opioid medicine? If yes, what? _____

- Please circle the number below that describes the extent to which your persistent pain interferes with your current normal daily activities.
Does not interfere at all 1 2 3 4 5 Constantly interferes
- How does your persistent pain make you feel? (Please check all boxes that apply)
 Angry Depressed Hopeless Sad Frustrated Anxious Not in control
 Other _____

Questions about breakthrough pain

1. Have you had breakthrough pain since your last visit? Yes No If yes, where? _____

2. How many times a day does your breakthrough pain occur? _____
At what times during the day? _____
3. What brings on your breakthrough pain? (Check one)
 It consistently happens just before I take my next dose of around-the-clock pain medicine.
 It happens as the result of a voluntary action (like getting up from a chair). If yes, describe the action: _____
 It happens as the result of an involuntary action (like coughing). If yes, describe the action: _____
 There doesn't seem to be any cause, it just comes on by itself.
4. How long does it take for your breakthrough pain to reach its worst intensity?
 Under 5 minutes 5 to 10 minutes 10 to 20 minutes 20 to 30 minutes Over 30 minutes
5. How long does your breakthrough pain typically last? _____
6. Using the faces scale on the left, please circle the number below that describes the intensity of your breakthrough pain. If you have more than 1 kind of breakthrough pain, circle up to 2 numbers. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
7. How would you best describe your breakthrough pain? (Please check all boxes that apply)
 Aching Burning Dull Numb Sharp Shooting Stabbing
 Throbbing Tingling Other _____
8. Please circle the number below that describes the extent to which your breakthrough pain interferes with your current normal daily activities.
Does not interfere at all 1 2 3 4 5 Constantly interferes
9. How does your breakthrough pain make you feel? (Please check all boxes that apply)
 Angry Depressed Hopeless Sad Frustrated Anxious Not in control
 Other _____



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