California HERNIA SPECIALISTS

ACHQC ABDOMINAL CORE HEALTH QUALITY COLLABORATIVE

Patient Name: _____

Postoperative Assessment

How many tablets of prescription opioid pain medication did you take in the past 30 days?

_____

In total, how many tablets of prescription opioid pain medication were you prescribed after your surgery? _____

In the past 7 days…	Had no pain	Mild	Moderate	Severe	Very Severe
How intense was your pain at its worst?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How intense was your average pain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
What is your level of pain right now?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Regarding your hernia operation…

Do you feel your hernia has come back? ☐Yes ☐No

Do you feel or see a bulge? ☐Yes ☐No

Do you have physical pain or symptoms at the site? ☐Yes ☐No

Have you had additional surgery since your hernia operation? ☐Yes ☐No

If yes, reason for abdominal surgery:

☐For hernia ☐For another reason

For the following statements, please circle the number that is most appropriate for you :

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. My **abdominal wall** has a huge impact on my health	1	2	3	4	5	6
2. My **abdominal wall** causes me physical pain	1	2	3	4	5	6
3. My **abdominal wall** interferes when I perform strenuous activities, e.g. heavy lifting	1	2	3	4	5	6
4. My **abdominal wall** interferes when I perform moderate activities, e.g. bowling, bending over	1	2	3	4	5	6
5. My **abdominal wall** interferes when I walk or climb stairs	1	2	3	4	5	6
6. My **abdominal wall** interferes when I dress myself, take showers, and cook	1	2	3	4	5	6
7. My **abdominal wall** interferes with my sexual activity	1	2	3	4	5	6
8. I often stay at home because of my **abdominal wall**	1	2	3	4	5	6
9. I accomplish less at home because of my **abdominal wall**	1	2	3	4	5	6
10. I accomplish less at work because of my **abdominal wall**	1	2	3	4	5	6
11. My **abdominal wall** affects how I feel every day	1	2	3	4	5	6
12. I often feel blue because of my **abdominal wall**	1	2	3	4	5	6

Please answer all of the 9 following questions in the 3 main fields of:

1. **Pain of the side of the hernia**
2. **Restrictions of activities because of pain or discomfort**
3. **Cosmetic discomfort**

Therefore, please mark a number corresponding to your current state.

Respectively, you will give a 0 (no pain, no restriction and cosmetically beautiful) **for the best conditions and a 10 for the worst state** (worst pain, completely restricted and cosmetically ugly)**. If you do not perform one of these asked activities, please mark the X in the last column.**

1. Pain at the site of the hernia												
	0 = no pain										**10 = worst pain imaginable**	
Pain in rest (lying down)	0	1	2	3	4	5	6	7	8	9	10	
Pain during activities (walking, biking, sports)	0	1	2	3	4	5	6	7	8	9	10	
Pain felt during the last week	0	1	2	3	4	5	6	7	8	9	10	

2. Restrictions of activities because of pain or discomfort at the site of the hernia												
	0 = no restriction										**10 = completely restricted**	
Restriction from daily activities (inside the house)	0	1	2	3	4	5	6	7	8	9	10	X
Restriction outside the house (walking, biking, driving)	0	1	2	3	4	5	6	7	8	9	10	X
Restriction during sports	0	1	2	3	4	5	6	7	8	9	10	X
Restriction during heavy labour	0	1	2	3	4	5	6	7	8	9	10	X
	X = If you do not perform this activity											

3. Cosmetic discomfort												
	0 = very beautiful										**10 = extremely ugly**	
Shape of your abdomen	0	1	2	3	4	5	6	7	8	9	10	
Site of the hernia	0	1	2	3	4	5	6	7	8	9	10	