

PREOPERATIVE ASSESSMENT

Patient Name: _____

What would your doctor need to know regarding your experience of your hernia to take good care of you?

Please respond to each item by marking one box per row.

In the past 7 days...	Had no pain	Mild	Moderate	Severe	Very Severe
How intense was your pain at its worst?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How intense was your average pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
What is your level of pain right now?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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

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

Strongly Disagree
Moderately Disagree
Slightly Disagree
Slightly Agree
Moderately Agree
Strongly Agree

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	