Name_____ Month _____ Year _____

Medications List

A.
B.
C.
D.
E.
F.
G.

DIRECTIONS

1. Rate the pain you are experiencing using scale below.
2. If at "4" take med and continue to monitor pain rating on sheet.
3. Note what level pain drops to, take meds only when pain returns to "4"
4. Stop meds and get rid of them as soon as they are no longer needed.

Evening	Hours																								Day
	6	7	8	9	10	11	M	1	2	3	4	5	6	7	8	9	10	11	N	1	2	3	4	5	
31																									1
1																									2
2																									3
3																									4
4																									5
5																									6
6																									7
7																									8
8																									9
9																									10
10																									11
11																									12
12																									13
13																									14
14																									15
15																									16
16																									17
17																									18
18																									19
19																									20
20																									21
21																									22
22																									23
23																									24
24																									25
25																									26
26																									27
27																									28
28																									29
29																									30
30																									31
31																									1

Pain Rating Scale

0. No pain at all
1. Slight Pain, some sensations are noticeable
2. Mildly Painful, can be ignored
3. Moderately Painful, can be tolerated without medicine
4. Painful, medication is needed to tolerate the pain in order to function well
5. Severe Pain, needs medication and medical services

(OVER for additional comments)

Name_____ Month _____ Year _____

Date	Time	Comment