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| **疼痛情况更新表 (Pain Update)** |

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| **姓（英文）：** | | | | | | | | | | **名（英文）：** | | | | | | | | | | | **今天的日期：**  \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | | |
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|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | |
| 在过去一周中，您经历的疼痛平均分为多少分？ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 0 | | 1 | | 2 | | 3 | | | | 4 | | 5 | | | 6 | | 7 | | 8 | | | | 9 | 10 |  |
| 无疼痛 | |  | |  | |  | |  | | | |  | |  |  | |  | |  | | |  | | | 能想象最剧烈的疼痛 | |

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| 在过去一周中，疼痛至多大程度影响您日常的活动？ | | | | | | | | | | | | | | | | | | |
|  | 0 | 1 | | 2 | 3 | 4 | 5 | 6 | | 7 | 8 | | 9 | | 10 | |  | |
| 没有影响 | | |  | | | | | | | | | | | | | 完全影响 | | |
| 在过去一周中，以下陈述那个对你适用？ | | | | | | | | | 完全没有 | | | 些许程度或有时如此 | | 相当程度或经常如此 | | | | 非常大的程度或几乎总是如此 |
| 我意识到自己口干舌燥 | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |
| 我觉得没什么事值得期待 | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |
| 我觉得自己几乎感到惊恐不已 | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |
| 我对任何事都没有热诚 | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |
| 我觉得自己毫无价值 | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |
| 我在没有体力活动的情况下能感觉到自己的心跳 （例如：感觉心跳加快或心跳漏了一拍） | | | | | | | | | 0 | | | 1 | | 2 | | | | 3 |

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| 就算您现在感觉疼痛，您认为您是否能做到以下的事？请按照您的信心程度评分。 | | | | | | | | | | | | | | | | |
| 虽然感觉疼痛，我仍可以做某些工作（“工作”包括家务、给薪和不给薪的工作） | | 0 | | 1 | | 2 | | 3 | | | 4 | | | 5 | | 6 |
| 完全无信心 | | | | | | | 完全有信心 | | | | | | | |
| 虽然感觉疼痛，我仍可以过正常的生活 | | 0 | | 1 | | 2 | | 3 | | | 4 | | | 5 | | 6 |
| 完全无信心 | | | | | | | 完全有信心 | | | | | | | |
| 请标明您感觉疼痛时有以下想法或感觉的频繁程度 | | | 不曾 | | 偶尔 | | 有时 | | | | | | 经常 | | 总是 | |
| 情况很糟糕，我觉得情况永远不会改善 | | | 0 | | 1 | | 2 | | | | | 3 | | | 4 | |
| 我担心疼痛会加剧 | | | 0 | | 1 | | 2 | | | | | 3 | | | 4 | |
| 我无法不去想它 | | | 0 | | 1 | | 2 | | | | | 3 | | | 4 | |
| 我一直想着这疼痛怎不快快消失 | | | 0 | | 1 | | 2 | | | | | 3 | | | 4 | |
| 过去一周中，您做了几个小时的给薪工作？ | | | | | | | | | | …………………..小时 | | | | | | |
| 过去**3个月**中，您做了以下事情的次数是**….** | | | | | | | | | | | | | | | | |
| …. 因疼痛而去了医院急诊室 | | | | | | | | | | …………………. 次 | | | | | | |
| …. 因疼痛而住院接受治疗 | | | | | | | | | | …………………. 次 | | | | | | |
| 请列明您目前使用的所有药物（包括处方和非处方药物） | | | | | | | | | | | | | | | | |
| **药物名称**  **（如标签上注明）** | **药物强度**  **（如标签上注明）** | | | | **每天服用多少药量？** | | | | | | | **一周服用该药几天？** | | | | |
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