

PHI

I Pain

1. Do you currently have pain?

☐ Yes ☐ No (*if no, please go to subsection II Emotional states, p. 2*)

If yes, please answer the following questions about your pain:

2. Where do you have pain?

- | | | |
|-----|------------------------|--------------------------|
| 1. | Mouth/ Face/ Head | <input type="checkbox"/> |
| 2. | Neck and throat region | <input type="checkbox"/> |
| 3. | Shoulder/ Arm/ Hand | <input type="checkbox"/> |
| 4. | Chest area | <input type="checkbox"/> |
| 5. | Abdominal area | <input type="checkbox"/> |
| 6. | Back area | <input type="checkbox"/> |
| 7. | Hip/ Leg/ Foot | <input type="checkbox"/> |
| 8. | Pelvic area | <input type="checkbox"/> |
| 9. | Genitals/ anus | <input type="checkbox"/> |
| 10. | Joints | <input type="checkbox"/> |
| 11. | Entire body | <input type="checkbox"/> |

If you have pain **in more than one area**, please answer the following questions in relation to your **pain that is currently most severe**.

3. On the following scale, please mark the number that best represents the intensity of your pain.

Example: Your pain is of medium intensity

(0) (1) (2) (3) (4) **X** (6) (7) (8) (9) (10)
No pain Worst pain imaginable

- 3a. How severe is your pain?

At rest...

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
No pain Worst pain imaginable

- 3b. How severe is your pain?

With physical activity (e.g. walking, sitting, picking up something from the floor)...

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
No pain Worst pain imaginable

4. Since when do you have this pain? *Please mark the applicable answer category*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For hours	For days	For weeks	Up to half a year	For have a year or longer

5. How often do you have the pain? *Please mark the applicable answer category*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly	Several times a day	Once a day	Every couple of days	Every few weeks	rarer

6. Is this pain related to the upcoming surgery?

Yes ☐ No ☐

II Emotional states

The next questions are about how you are feeling. For each statement, please mark the number that corresponds best to the intensity of emotional state.

You do not feel anxious at all

~~0~~ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not anxious at all Very anxious

You feel very anxious

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) ~~10~~
Not anxious at all Very anxious

How do you feel the last days and today?

a) I feel **sad**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not sad at all Very sad

b) I feel **anxious**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not anxious at all Very anxious

c) I am **tired**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not tired at all Very tired

d) I feel **numb**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not numb at all Very numb

e) I feel **weak**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not weak at all Very weak

f) I feel **irritated**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not irritated at all Very irritated

g) My **mood** is overall:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Good, without impairment Bad, severe impairment

III General state of health

For this question, please indicate how you would rate your overall health. Please mark the category that applies best to you.

How are you? My general state of health is:

- | | |
|------------------|--------------------------|
| 1. Very good | <input type="checkbox"/> |
| 2. Good | <input type="checkbox"/> |
| 3. Rather good | <input type="checkbox"/> |
| 4. Moderate | <input type="checkbox"/> |
| 5. Rather bad | <input type="checkbox"/> |
| 6. Bad | <input type="checkbox"/> |
| 7. Very bad | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |

II Emotional states

The next questions are about how you are feeling. For each statement, please mark the degree that corresponds best to the intensity of emotional state.

You do not feel anxious at all

☒ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not anxious at all Very anxious

You feel very anxious

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) ☒
Not anxious at all Very anxious

How did you feel the last days and today?

a) I feel **sad**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not sad at all Very sad

b) I feel **anxious**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not anxious at all Very anxious

c) I am **tired**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not tired at all Very tired

d) I feel **numb**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not numb at all Very numb

e) I feel **weak**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not weak at all Very weak

f) I feel **irritated**:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Not irritated at all Very irritated

g) My **mood** is overall:

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Good, without impairment Bad, severe impairment

III General state of health

For this question, please indicate how you would rate your overall health. Please mark the category that applies best to you.

How are you? My general state of health is:

- | | |
|------------------|--------------------------|
| 1. Very good | <input type="checkbox"/> |
| 2. Good | <input type="checkbox"/> |
| 3. Rather good | <input type="checkbox"/> |
| 4. Moderate | <input type="checkbox"/> |
| 5. Rather bad | <input type="checkbox"/> |
| 6. Bad | <input type="checkbox"/> |
| 7. Very bad | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |

IV Somatic parameters

Mobility

Please indicate how much exercise you did today. Please mark the appropriate category.

How much did you move today?

- | | |
|--|--------------------------|
| 1. I was only in bed | <input type="checkbox"/> |
| 2. I had physiotherapy in bed | <input type="checkbox"/> |
| 3. I sat down in bed | <input type="checkbox"/> |
| 4. I went to the bathroom with help of others | <input type="checkbox"/> |
| 5. I walked around with the help of physiotherapist/ nurse | <input type="checkbox"/> |
| 6. I went to the bathroom without help | <input type="checkbox"/> |
| 7. I walked around with the help of others (e.g. visitors) | <input type="checkbox"/> |
| 8. I walked around without help of others | <input type="checkbox"/> |

Do you think, you could have done more exercise?

- | | |
|--|--------------------------|
| Yes, I could have done more exercise | <input type="checkbox"/> |
| I am content with my level of exercise | <input type="checkbox"/> |
| No, I was overstrained with my level of exercise | <input type="checkbox"/> |

Diet

Please indicate what you ate/drank today. Please mark the appropriate category.

- | | |
|---|--------------------------|
| 1. No food/ drink | <input type="checkbox"/> |
| 2. Limited tea/ water | <input type="checkbox"/> |
| 3. Unlimited tea/ water | <input type="checkbox"/> |
| 4. Soup/ yoghurt | <input type="checkbox"/> |
| 5. Mashed food | <input type="checkbox"/> |
| 6. Light to normal diet (including diabetic food) | <input type="checkbox"/> |

Do you think, you could have tolerated more/other nourishments?

- | | |
|--|--------------------------|
| Yes, I would have tolerated more/ other nourishments | <input type="checkbox"/> |
| I tolerated everything I ate/drunk | <input type="checkbox"/> |
| No, I did not tolerate the received nourishments | <input type="checkbox"/> |

PHI — External assessment for nursing care, physiotherapists, and physicians

Preoperatively

Nursing Care

General state of health

For this question, please indicate how you would rate the overall health of the patient. Please mark the category that applies best.

How is the patient? The general state of health of the patient is:

- | | |
|------------------|--------------------------|
| 1. Very good | <input type="checkbox"/> |
| 2. Good | <input type="checkbox"/> |
| 3. Rather good | <input type="checkbox"/> |
| 4. Moderate | <input type="checkbox"/> |
| 5. Rather bad | <input type="checkbox"/> |
| 6. Bad | <input type="checkbox"/> |
| 7. Very bad | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |

Physician

Lung function: FEV₁ _____ FVC _____

Analgesics: No ☐ Yes ☐ Which? _____
How much? _____

Health condition assessment:

Please indicate how you would currently assess the patient's health condition generally.

- | | |
|---------------------------------|--------------------------|
| 1. Very good health condition | <input type="checkbox"/> |
| 2. Good health condition | <input type="checkbox"/> |
| 3. Rather good health condition | <input type="checkbox"/> |
| 4. Moderate health condition | <input type="checkbox"/> |
| 5. Rather bad health condition | <input type="checkbox"/> |
| 6. Bad health condition | <input type="checkbox"/> |
| 7. Very bad health condition | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |

Postoperatively

Nursing Care

General state of health

For this question, please indicate how you would rate the overall health of the patient. Please mark the category that applies best.

How is the patient? The general state of health of the patient is:

- | | |
|------------------|--------------------------|
| 1. Very good | <input type="checkbox"/> |
| 2. Good | <input type="checkbox"/> |
| 3. Rather good | <input type="checkbox"/> |
| 4. Moderate | <input type="checkbox"/> |
| 5. Rather bad | <input type="checkbox"/> |
| 6. Bad | <input type="checkbox"/> |
| 7. Very bad | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |

Somatic parameters

For this question, please indicate what the patient ate/drank today. Please mark the appropriate category.

- | | |
|---|--------------------------|
| 1. No food/ drink | <input type="checkbox"/> |
| 2. Limited tea/ water | <input type="checkbox"/> |
| 3. Unlimited tea/ water | <input type="checkbox"/> |
| 4. Soup/ yoghurt | <input type="checkbox"/> |
| 5. Mashed food | <input type="checkbox"/> |
| 6. Light to normal diet (including diabetic food) | <input type="checkbox"/> |

Physiotherapists

Somatic parameters

Please indicate how much exercise the patient did today. Please mark the appropriate category.

How much did the move today?

- | | |
|---|--------------------------|
| 1. S/he was only in bed | <input type="checkbox"/> |
| 2. S/he had physiotherapy in bed | <input type="checkbox"/> |
| 3. S/he sat down in bed | <input type="checkbox"/> |
| 4. S/he went to the bathroom with help of others | <input type="checkbox"/> |
| 5. S/he walked around with the help of physiotherapist/ nurse | <input type="checkbox"/> |
| 6. S/he went to the bathroom without help | <input type="checkbox"/> |
| 7. S/he walked around with the help of others (e.g. visitors) | <input type="checkbox"/> |
| 8. S/he walked around without help of others | <input type="checkbox"/> |

Physician

Lung function: FEV₁ _____ FVC _____

Analgesics: No ☐ Yes ☐ Which? _____

How much? _____

Received PCA: No ☐ Yes ☐ How much? _____

Status evaluation:

Please indicate how you would currently assess the patient's health condition generally.

- | | |
|---------------------------------|--------------------------|
| 1. Very good health condition | <input type="checkbox"/> |
| 2. Good health condition | <input type="checkbox"/> |
| 3. Rather good health condition | <input type="checkbox"/> |
| 4. Moderate health condition | <input type="checkbox"/> |
| 5. Rather bad health condition | <input type="checkbox"/> |
| 6. Bad health condition | <input type="checkbox"/> |
| 7. Very bad health condition | <input type="checkbox"/> |
| 8. I do not know | <input type="checkbox"/> |