



# VAS Pain Assessment Score

eform v 3.1

Patient Name: \_\_\_\_\_

Side:  Left

Patient ID: \_\_\_\_\_

Right

Date of review:         (complete either the date of review or the follow up period below)

Follow up period: Pre Op OR \_\_\_\_\_ Weeks / Months / Years (add the delay and circle one)

Simply place a vertical line at the position on the line below that corresponds accurately with your perception of your answer to the question. Please ensure that your line crosses the horizontal line, inside the shaded area.

The further to the left you put your line, the less you experience pain, the further to the right you put your line, the more you experience pain.

NO PAIN

EXTREME PAIN