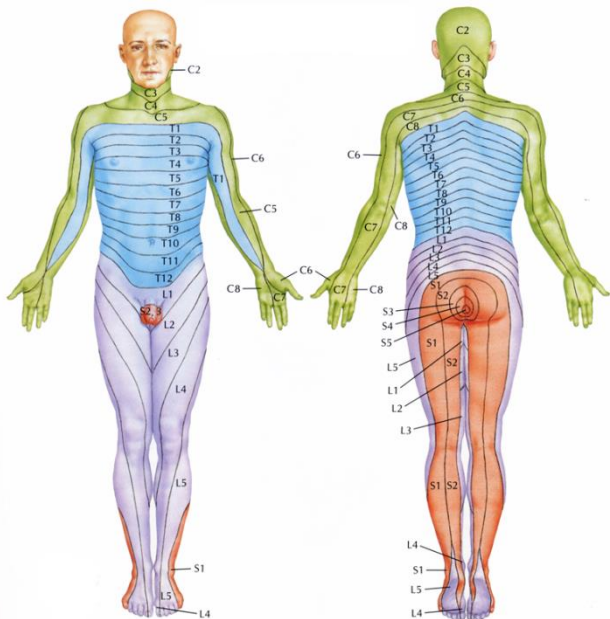


Cognome _____ Nome _____ data _____
 cartella n° _____ Unità Operativa _____
 diagnosi d'ingresso _____



Dolore
 acuto somatico
 cronico viscerale
 cronico riacutizzato a riposo
 breakthrough pain in movimento

Sede _____

Irradiazione _____

da quanto tempo è presente il dolore _____

Come descrive il suo dolore?	<input type="checkbox"/> crampiforme	<input type="checkbox"/> urente	<input type="checkbox"/> elettrico
<input type="checkbox"/> tagliente	<input type="checkbox"/> sordo	<input type="checkbox"/> gravativo	<input type="checkbox"/> costrittivo
<input type="checkbox"/> pulsante	<input type="checkbox"/> altro (specificare)		
Disturbi neurologici associati	<input type="checkbox"/> anestesia	<input type="checkbox"/> ipoestesia	<input type="checkbox"/> iperestesia
<input type="checkbox"/> parestesie	<input type="checkbox"/> iperalgesia	<input type="checkbox"/> allodinia	<input type="checkbox"/> prurito
<input type="checkbox"/> deficit motori	<input type="checkbox"/> altro/note		

Note anamnestiche relative al dolore

Diagnosi algologica

NRS segnare una X sul numero corrispondente all'intensità del dolore

1	2	3	4	5	6	7	8	9	10
NO DOLORE	LIEVE	MODERATO	FORTE	INSOPPORTABILE					

dolore nocicettivo
 dolore neuropatico

0: il dolore non interferisce 1: interferisce a volte 2: interferisce spesso o sempre










































































































attività lavorativa	①	①	②	il dolore le impedisce di dormire	<input type="checkbox"/> Si	<input type="checkbox"/> No
relazioni sociali o interpersonali	①	①	②	note d'ansia	<input type="checkbox"/> Si	<input type="checkbox"/> No
relazioni affettive	①	①	②	note di depressione	<input type="checkbox"/> Si	<input type="checkbox"/> No










































































































terapia effettuata

terapia in corso

terapia prescritta

firma medico

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