

# backrelief.com MD Information Sheet

Wyeth Consumer Healthcare Inc., the makers of Robax Platinum®, would like to offer you these printable pages that you, as a back pain sufferer, can fill out and take with you to the doctor to help him/her better understand 'where it hurts' and what might be done about it. This information will help you describe your pain to the doctor and help him/her make the diagnosis more efficiently.

Your doctor will likely have other questions in addition to these and this should not be used for the purposes of self-diagnosis. Seek immediate medical attention if you experience any of the following: numbness, loss of bladder or bowel control, or pain that is severe or lasts longer than a week.

1) Where is the pain and/or numbness located? [TICK ALL THAT APPLY]

- confined to the lower back
- it radiates to the buttocks and legs
- neck or upper back or radiating to the shoulder/arm

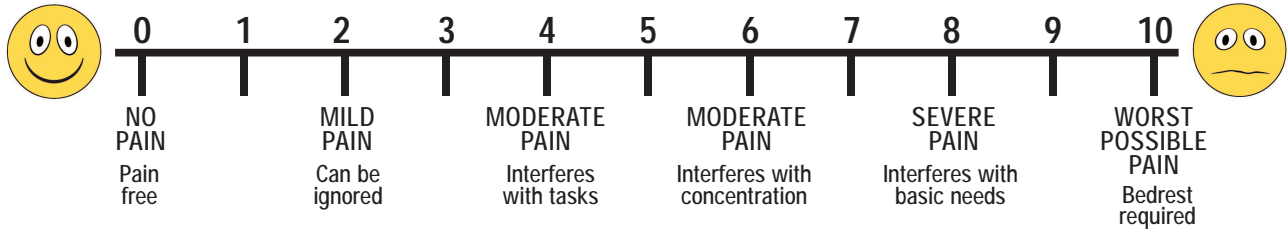
2) When did the pain begin? (Approximate date)

\_\_\_ / \_\_\_ / \_\_\_  
D M Y

3) Did the back pain you are now experiencing start...

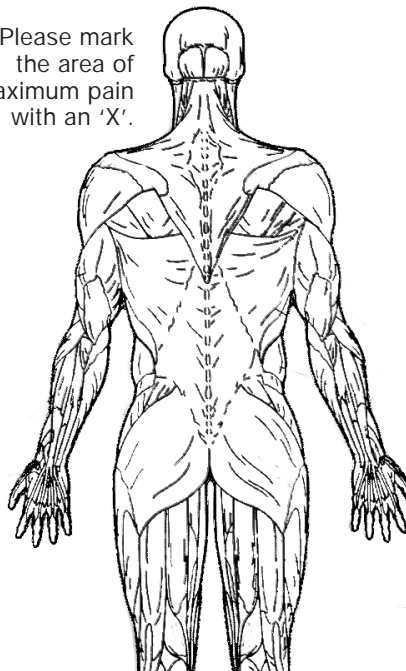
- after an injury or accident
- while you were lifting
- when you awoke after sleeping
- just bending over
- working... in the garden, on the job
- while playing sports
- following a sneezing or coughing episode
- other, please specify \_\_\_\_\_

4) How severe is the pain? Please use the scale and descriptions below to indicate how much the pain affects you. [CIRCLE ONE]



5) Where is the back pain worst?

Please mark the area of maximum pain with an 'X'.



6) How long does the pain last on average?

- less than an hour       5 – 8 hours  
 1 – 2 hours       almost continuously  
 3 – 4 hours

7) Select one of the phrases below that best describes the kind of back pain you feel.

- sharp pain       stiffness  
 dull ache       sore muscles  
 burning pain

8) When is your pain the worst?

- when I wake       later in the day  
 no difference       other, please specify \_\_\_\_\_

9) What makes the pain feel better or worse?

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10) Did you take any medications to treat the pain?

- Yes – Answer Q. 11       No – Skip to Q. 13

11) What medication have you been taking? [WRITE IN BRAND NAMES]

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12) For how long did it provide relief, if at all?

- provided almost no relief       provided about \_\_\_\_ hours of relief per dose

13) Has there been a prior episode or prior episodes of pain?

- Yes – Answer Q. 14       No – Skip to Q. 18

14) How was the pain treated?

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15) How effective was the treatment? [TICK ONE BOX ONLY]

- Very effective       Not very effective  
 Somewhat effective       Not affective at all

16) What caused the previous episode(s)?

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17) And how long did the pain last?

\_\_\_ Days     \_\_\_ Weeks     \_\_\_ Months

18) Are you experiencing any other health problems?

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19) Which of the following activities does your work usually involve?

- |   |   |
|---|---|
| <input type="checkbox"/> sitting at a desk or counter | <input type="checkbox"/> spend hours on the phone       |
| <input type="checkbox"/> standing for hours at a time | <input type="checkbox"/> strenuous physical labour      |
| <input type="checkbox"/> walking for long periods     | <input type="checkbox"/> repetitive bending or twisting |
| <input type="checkbox"/> repetitive lifting           | <input type="checkbox"/> other, please specify_____     |

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**Additional comments:**