STUDY ID #:_ _ _ _ _ _ _ _ _ _ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_ _ _ _ _ _ _ _ _ _

ZOSTER BRIEF PAIN INVENTORY (ZBPI)

Zoster Brief Pain Inventory (ZBPI) Instructions

People with shingles may have many kinds of **pain or discomfort** in the area of their shingles rash. These sensations may persist or come back in the area of the shingles rash **even after the rash disappears**.

When answering the following questions about **pain**, please include all kinds of **pain** in the area of your shingles rash, including pain triggered by air blowing on the skin, by clothing rubbing against the skin, or by hot or cold temperatures.

Do **not** include pain or discomfort that is unrelated to your shingles, such as low back pain, arthritis pain, or headache.

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

ZOSTER BRIEF PAIN INVENTORY (ZBPI)

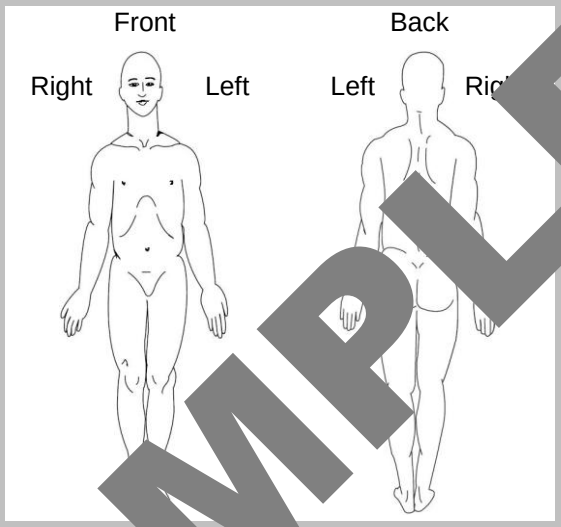
Date: ____/____/_____ Time: _____

Name: _____ _____ _____
Last First Middle Initial

1. Have you had any pain caused by your shingles in the last 24 hours?

1. **Yes** 2. **No**

2. On the diagram, **shade** in the areas where you feel pain. **Put an "X" on the area that hurts the most**.



3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **average** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **right now.**

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center

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ZOSTER BRIEF PAIN INVENTORY

Date: ____/____/_____ Time: _____

Name: _____ _____ _____
Last First Middle Initial

7. Are you receiving any treatments or medications for your **shingles pain**?

1. **Yes** 2. **No**

8. In the last 24 hours, how much **relief** have these treatments or medications provided for your **shingles pain**? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Relief Complete Relief

9. Circle the one number that describes how, in the last 24 hours, **shingles pain has interfered with your**:

A. **General Activity**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

B. **Mood**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

C. **Walking Ability**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

D. **Normal Work** (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

E. **Relations with other people**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

F. **Sleep**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

G. **Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes