POST-OP FOLLOW UP SHEET

_____/_____/_____

Patient Name Date Physician you are seeing today?

Chief Complaint (CC)

Why are you here today? _____ What was your date of surgery? _____

Quality: What type of pain are you having today? ❑ Burning ❑ Diffuse ❑ Dull/Aching ❑ Localized

❑ Radiating ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing ❑ Tightness ❑ Tingling

Do you have any of the following? ❑ Fever ❑ Chills ❑ Drainage at wound ❑ Swelling

What is your level of pain today? 0 1 2 3 4 5 6 7 8 9 10 most severe

Current Work Status: Please check off your current work status if you are a workers compensation patient.

❑ Regular Duty ❑ Light Duty ❑ Not Working due to this injury ❑ Disabled ❑ Retired ❑ Student

REVIEW OF SYSTEMS **Have you had any problems related to the following systems?** ***Circle all that apply***

If "No" mark NONE / If "Yes" write Details or Comments below

Constitutional Systems	Chills	Fever	Headache	None
Eyes	Blurred	Double Vision	Vision Change	None
Ear/Nose/Throat	Earache	Sore Throat	Sinus Congestion	None
Cardiovascular	Chest Pain	Shortness of Breath	Palpations	None
Respiratory	Chronic Cough	Wheezes	Asthma	None
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes	None
Genitourinary	Frequent Urination	Urine Retention	Kidney Problems	None
Musculoskeletal	Neck Pain	Back Pain	Joint Pain	None
Skin	Rash	Skin Discolor	Persistent Itch	None
Neurologic	Stroke	Weakness	Vertigo	None
Psychiatric	Anxiety	Depression	Sleep Disorders	None
Endocrine	Thirst Increase	Sweats	Thyroid Disease	None
Hematologic/Lymphatic	Swollen Glands	Blood Clotting Problem	Anemia	None
Allergic/Immunologic	Hay Fever			None