HOSPITAL FOR SPECIAL SURGERY
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Postoperative Visit

Today's Date _____

Name: _____ Age: _____ DOB: _____

Date of Surgery: _____

Name Of Surgery: _____

Have you had any of the following symptoms:

☐ Fever	☐ Swelling	☐ Nausea/Vomiting
☐ Chills	☐ Chest Pain	☐ Constipation
☐ Drainage from the wound	☐ Shortness of Breath	☐ Other

Rate Your Pain on a Scale of 0-10 *(0 = No Pain 10 = Extreme Pain):*
Right Now: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe Pain:

☐ Sharp	☐ Throbbing	☐ Stiff	☐ Tingling
☐ Dull	☐ Radiating	☐ Burning	☐ Other
☐ Aching	☐ Shooting	☐ Numbness	

Have there been any changes to your health? ☐ Yes ☐ No
If yes please list:

Are you taking any new medications: ☐ Yes ☐ No
If yes please list:

Please list any specific questions you would like addressed today: