Post-Operative Medical History Questionnaire

Instructions: Please complete this questionnaire thoroughly to help monitor your post-operative recovery. Since this form is for print, you may fill it out digitally or write your answers clearly after printing.

1. Patient Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Emergency Contact Name & Relation:

Emergency Contact Phone:

2. Surgical Procedure Details

Date of Surgery (MM/DD/YYYY):

Surgical Procedure Performed:

Operating Surgeon:

Hospital or Surgical Center Name:

3. Current Symptoms and Recovery Status

Current Pain Level (Scale of 0 to 10, with 10 being worst):

Is your pain controlled by the prescribed pain medication? (Yes / No / Partially):

Are you experiencing any swelling, redness, or warmth around the incision site? (Yes / No):

Is there any fluid or blood leaking from your surgical wound? (If yes, describe color and amount):

Have you checked your temperature? (Enter current temperature if known, e.g., 98.6 F):

Are you experiencing any nausea, vomiting, dizziness, or shortness of breath? (Yes / No):

4. Post-Operative Medications

List all pain medications you are currently taking:

Are you currently taking any prescribed antibiotics? (If yes, specify name):

Have you resumed your regular daily home medications? (Yes / No / Partially):

List any known drug allergies or adverse reactions experienced since surgery:

5. Mobility and Daily Functions

Are you able to walk and move around as instructed? (Yes / No):

Have you been able to urinate and have a bowel movement normally since surgery? (Yes / No):

Are you tolerating liquids and solid foods without difficulty? (Yes / No):

6. Patient Attestation

I certify that the information provided above is accurate to the best of my knowledge.

Patient or Guardian Signature (Sign here):

Date Signed (MM/DD/YYYY):