

Post-Surgery Patient Recovery Feedback Form

Please complete this form to help your healthcare team monitor your recovery progress. This printed form is designed to be filled out manually or via text entry.

1. Patient & Surgery Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Date of Surgery (MM/DD/YYYY):

Type of Surgery / Procedure:

Surgeon Name:

2. Pain & Medication Management

Current Pain Level (Scale 1 to 10, where 10 is worst):

Are you taking your prescribed pain medications as directed? (Yes / No / Comments):

Are you experiencing any medication side effects? (Describe):

3. Physical Recovery & Symptoms

Describe your current mobility and activity level (e.g., walking, sitting up):

How does the incision site look? (e.g., dry, red, swelling, leaking fluid):

Do you have a fever? (Please record temperature if known):

4. Support & Communication

Do you have adequate support at home for daily tasks? (Yes / No / Comments):

Do you have any questions or concerns for your healthcare team?

Preferred Contact Phone Number: