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POST-OPERATIVE VISIT UPDATE FORM

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____ Primary Care Doctor:_____

What surgery did you recently have?_____ Date: _____

ARE YOU HAVING ANY PROBLEMS TODAY? □ No □ Yes, explain: _____

_____

_____

Please rate your current pain level: None 0 1 2 3 4 5 6 7 8 9 10 Horrible

Is your pain: □ Improving □ Worsening □ Staying the same

Are you taking any PAIN MEDICATIONS? □ No □ Yes, please list medication, dose & prescriber:

_____

_____

Is there anything that relieves or worsens your symptoms? _____

_____

Are you currently in Physical Therapy? □ No □ Yes, where?_____

Have you seen any other doctors since your last visit? □ No □ Yes, please explain: _____

_____

_____

Do you have any **NEW medical problems that have developed** since your last visit? _____

_____

_____

Have you stopped or started any **NEW medications** since your last visit? _____

_____

Do you have any **NEW allergies** to medications since your last visit? _____

_____

Patient Signature _____ Date _____

Provider Signature _____ Date _____