

SURGICAL RECOVERY LOG

Date: ____/____/____

PATIENT NAME
PROCEDURE
RECOVERY DAY #

TIME	PAIN (1-10)	MEDICATION / DOSAGE	FOOD/H2O	VITALS	OBSERVATIONS (SWELLING, DRESSING, MOOD)
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DAILY SUMMARY & PHYSICAL ACTIVITY NOTES

QUESTIONS FOR PHYSICIAN / SURGEON

Contact Emergency Services if: Difficulty breathing, heavy bleeding, or high fever.

Doctor Office: _____