

Name: _____

Date: _____

Procedure: _____ Date of Procedure _____ Date of Discharge: _____

- | | |
|---|----------------|
| 1. Are you showering daily? | Yes ___ No ___ |
| 2. Do you have a problem sleeping at night? | Yes ___ No ___ |
| 3. Is your appetite improving? | Yes ___ No ___ |
| 4. Do you become short of breath easily? | Yes ___ No ___ |
| 5. Do you use your breathing machine as instructed? | Yes ___ No ___ |
| 6. Is the level going lower on the breathing machine? | Yes ___ No ___ |
| 7. Are you short of breath at rest? | Yes ___ No ___ |
| 8. Do you sleep on three or more pillows? | Yes ___ No ___ |
| 9. Do you have chest wall numbness or tingling sensation? | Yes ___ No ___ |
| 10. Do you have pain or numbness in your fingertips? | Yes ___ No ___ |
| 11. Do you feel or hear clicking in your chest? | Yes ___ No ___ |
| 12. Have you had a chronic cough or cold since discharge? | Yes ___ No ___ |
| 13. Are your legs swollen most of the time? | Yes ___ No ___ |
| 14. Do you wear your support stockings during the day? | Yes ___ No ___ |
| 15. If you are a diabetic has your sugar been maintained less than 200? | Yes ___ No ___ |
| 16. Do you take your temperature daily? | Yes ___ No ___ |
| 17. Have you had a recent fever? | Yes ___ No ___ |
| 18. Did you develop a wound infection after surgery? | Yes ___ No ___ |
| 19. Have you seen your cardiologist since discharge from hospital? | Yes ___ No ___ |
| 20. Have you seen your primary physician since discharge from hospital? | Yes ___ No ___ |
| 21. Have you required any medical treatment since discharge? | Yes ___ No ___ |
| 22. Have any of your medications changed since leaving the hospital? | Yes ___ No ___ |
| 23. Do you still have moderate to severe pain? | Yes ___ No ___ |

On a pain scale of 0 – 10 (0 being no pain) please circle the appropriate # for you.

0 1 2 3 4 5 6 7 8 9 10

Do you have any complaints or concerns?

Reviewed by: _____ Date: _____