

Operation Note

John,Smith

DOB:January 20th, 1984

MRN: (Medical Record Number)

Date of Encounter: (Date)

Return: (Follow up appointment selected by doctor in treatment plan)

Diagnosis: (Surgery Perfomed)

Work Duty:Sedentary Work false greater than to the leftfalse until next

Chief Complaint: Left forearm and tingling

History of Presenting Illness

John Smith presents today for first post-op visit up. Since surgery, the patient (Fevers/chills/nausea/vomiting/chest pain/shortness of breath/calf/falls/trauma). He states his pain is (controlled/not controlled) (without medication/with medication including (free text box)). Pain is graded at (Pain Scale) level intensity. (He/She) (Is ambulating without any assistive devices/is ambulating with (Assistive Device)/is not ambulatory)

Examination:John Smith is an awake, alert and oriented male that appears his stated age. They have a pleasant demeanor. They are able to follow commands appropriately. They are in no acu

Vitals:

Skin:Incision is

(Clean/Dry/Intact/Erythema/Edema/Ecchymosis/Drainage/Dehiscense/Hematoma)

The patient has tenderness to palpation at:

Range of motion:

Strength:

Reflexes:

The patient has a positive: (Special Tests)

The patient has a negative: (Special Tests)

Distribution of Radiation:

Diagnostic Studies:

Assessment: (Name) is a (Age) year old (sex) S/P:

1.) (Surgery Perfomed)

Plan: (Name) presents with signs and symptoms consistent with (Diagnosis #1), (Diagnosis #2), Diagnosis, diagnostic studies, and treatment plans were reviewed with the patient at today's visit. Treatment plan includes (Treatment Plan buttons selected by doctor). The patient will follow up (in one week/in two weeks/in 3 weeks/in one month/in 6 weeks/ as needed/other). (The patient was provided with (DME item). The patient is happy with the plan moving forward.