

## Rooms Follow Up Form

Form no. 4

Patient's Number	
Patient's Surname	
Patient's Given Name	
Date of Birth	
Address	

### Activity Assessment

Rooms Follow Up Date	
Return to Work Date	
Return To Exercise/Sport Activity Date	

COMPLICATIONS	
Chest	<input type="checkbox"/>
Haematoma	<input type="checkbox"/>
Injury Intraabdominal Structure	<input type="checkbox"/>
Intestinal Ileus	<input type="checkbox"/>
Intestinal Obstruction	<input type="checkbox"/>
Nausea >6 Hours	<input type="checkbox"/>
Nerve Injury	<input type="checkbox"/>
Recurrent Hernia	<input type="checkbox"/>
Scrotal Haematoma	<input type="checkbox"/>
Wound Infection	<input type="checkbox"/>
NI	<input type="checkbox"/>

### Post Operative Examination

Post Operative Tenderness over Abdomen	<input type="checkbox"/>	NI
	<input type="checkbox"/>	Slight
	<input type="checkbox"/>	Severe

Post Operative Tenderness over Groins	<input type="checkbox"/>	NI
	<input type="checkbox"/>	Slight
	<input type="checkbox"/>	Severe

Post Operative Swelling	<input type="checkbox"/>	Abdominal
	<input type="checkbox"/>	Groin
	<input type="checkbox"/>	Scrotum
	<input type="checkbox"/>	NI

### Other Relevant Information

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### Pain Score

Nil	Mild	Moderate	Severe							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
0	1	2	3	4	5	6	7	8	9	10