

Post-Operative Nursing Assessment

Patient information										
Name:					Sex:					
Surgery performed:					Date of surgery:					
Surgeon:					Room number:					
Airway and breathing										
Respiratory rate: _____ breaths/min										
Depth and effort of breathing:			Normal		Shallow		Labored			
Breathing sounds:			Clear		Wheezing		Crackles			
Oxygen saturation: _____ %										
Oxygen therapy:			Room air		Nasal cannula		Mask			
Airway patency:			Clear		Obstructed					
Cardiovascular system										
Blood pressure: _____ mmHg										
Heart rate: _____ bpm										
Peripheral pulse:			Palpable		Diminished		Absent			
Capillary refill:										
Skin color and temperature:			Warm		Cool		Pale		Cyanotic	
Signs of bleeding or shock:			Yes		No					
Neurological status assessment										
Assessment used:										
Result:										
Orientation:			Oriented		Disoriented					
Pupillary response:			Equal		Unequal		Reactive		Non-reactive	
Motor function:			Intact		Impaired					
Sensation:			Normal		Abnormal					
Pain assessment										
Pain level:										
<div style="display: flex; justify-content: space-around; text-align: center;"> 1 2 3 4 5 6 7 8 9 10 </div>										
Location of pain:										

Description:				
Sharp	Dull	Throbbing	Burning	Other: _____
Duration of pain: _____ minutes/hours				
Pain aggravated by:				
Movement	Coughing	Deep breathing	Other: _____	
Pain relieved by:				
Medication	Positioning	Rest	Other: _____	
Wound and surgical site assessment				
Incision site:				
Dressing intact:				
Drainage:				
Type:				
Amount:				
Color:				
Signs of infection:	Redness	Swelling	Heat	Drainage
Wound edges:	Approximated	Dehisced		
Fluid and electrolyte balance assessment				
Intake and output:				
Signs of fluid overload/deficit:				
Electrolyte levels:				
IV therapy:				
Type:				
Rate:				
IV site condition:	Infiltrated	Swelling	Redness	Pain

Activity and mobility assessment

Ability to move extremities: Yes No

Assistance required: Yes No

Activity level:

Ambulate with assistance

Ambulate independently

Bedrest

Early mobilization: Initiated Not initiated

Assistance device provided: Yes No

If yes, indicate:

Psychosocial assessment

Emotional state:

Coping mechanism:

Patient concern or fears:

Other notes:

Nurse information

Name:

Signature: