TRACKING MY PROGRESS

Week #	S	M	T	W	Th	F	S	NOTES
Pain level **0 = none, 10 = high level**								
Pain Medication **Number of times needed**								
Incision Check **Redness - Swelling - Heat - Other**								
Redness or Swelling **Yes/No/Location**								
Prescribed Medications Taken **Yes/No**								
Exercise and Activity **Note Increase/Decrease in time or distance/Other**								
Normal Activities **Note changes in daily ability**								
Other								