

PATIENT HISTORY

Date _____

▪ **GENERAL INFORMATION**

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____

Emergency Contact Information

Name _____ Home Phone _____
Relationship _____ Cell Phone _____

What physician suggested you visit the Wound Healing Center?

Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

Who is your primary physician?

Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

Home Health Care/Nursing Home _____ Phone _____

Pharmacy _____ Phone _____

Have you ever been a patient at Chandler Regional Hospital? Yes No

▪ **WOUND HISTORY**

Wound location: _____

When did you first notice the wound? _____

How did your wound start? _____

Has it ever healed and then re-opened? Yes No

How have you been treating your wound until now? _____

Have you had any lab work done in the past month? No Yes, Who Ordered _____

Have you had any tests for circulation on your legs? No Yes, Where done _____

Who ordered _____

Have you had any other problems associated with your wound? (Please check)

Infection Swelling Other: _____



MEDICAL HISTORY Please check Yes or No for each item

	PATIENT		MANAGING PHYSICIAN	FAMILY		EXPLAIN (Who, Age)
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>If you have diabetes:</p> <p>Do you take: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled</p> <p>How long have you had diabetes? _____</p> <p>Do you test your blood sugar every day? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, how many times /day _____</p> <p>What are your blood sugar testing results? Breakfast_____ Lunch_____ Dinner_____</p> <p>Bedtime_____</p>
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis/Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Convulsion/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

HOSPITALIZATION/SURGERY HISTORY (Please list all past hospitalizations)

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

Staff Only: Reviewed by Staff (See Medical Summary)

SOCIAL HISTORY *Please check one for each item)*

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Previously, but quit _____ years ago Current packs per day _____

Alcohol Use: Never Rarely Moderate Daily

Drug Use: Never Type/Frequency _____

Caffeine Use: Never Type/Frequency _____

SYSTEM REVIEW *Please check Yes or No for each item*

GENERAL SYMPTOMS

Good general health lately Yes No

Fatigue Yes No

Height _____ Weight: _____

EYES

Glaucoma Yes No

Cataracts Yes No

EARS/NOSE/MOUTH/THROAT

Chronic sinus problems or rhinitis Yes No

Sore throat or mouth sores Yes No

Swollen glands in neck Yes No

GASTROINTESTINAL

Frequent diarrhea Yes No

Constipation Yes No

Blood in stool Yes No

INTEGUMENTARY (Skin)

Bleeding or bruising tendency Yes No

Change in mole Yes No

MUSCULOSKELETAL

Joint pain Yes No

Joint stiffness Yes No

Weakness of muscles or joints Yes No

Back Pain Yes No

Osteoarthritis Yes No

NEUROLOGICAL

Frequent /recurring headaches Yes No

Light headed or dizzy Yes No

Staff Only: Reviewed by Staff (See Medical Summary)

CARDIOVASCULAR

Chest Pain Yes No

Pacemaker: Yes No

If yes, Manufacturer _____

RESPIRATORY

Chronic or frequent coughs Yes No

Spitting up blood Yes No

Shortness of breath/Sleep apnea Yes No

Asthma/Emphysema/TB Yes No

PSYCHIATRIC

Depression Yes No

Claustrophobia Yes No

ENDOCRINE/HEPATIC

Thyroid disease Yes No

Excessive thirst/urination Yes No

Heat/cold intolerance Yes No

Hepatitis Yes No

HEMATOLOGIC/LYMPHATIC

Anemia Yes No

Human Immunodeficiency Virus Yes No

GENITOURINARY

Frequent urination Yes No

Blood in urine Yes No

Incontinence/dribbling Yes No

Kidney failure/ Dialysis Yes No

Kidney transplant Yes No

Staff Only: ABNORMALITIES ADDRESSED BY RN

CURRENT HEALTH STATUS (Please check one for each item)

- | | | | |
|--------------------|-------------------------------|-------------------------------|-------------------------------|
| Energy Level | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Physical Function | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Social Functioning | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Mental Health | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Health Perception | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

NUTRITION PROFILE Please check Yes or No for each item

- Difficulty chewing or swallowing? Yes No
- Do you need assistance with eating? Yes No
- Have you had a large weight loss? Yes No
- Have you had a large weight gain?
If yes, _____pounds in _____months. Reason, if known _____ Yes No
- Special diet? Yes No
- Food allergies? Yes No
- Are you involved in weight loss program? Yes No
- Weight Loss Medications: _____
- How many meals do you eat each day? _____
- Appetite: Good Fair Poor (Please check one)
- Do you take nutritional supplements? Yes No
- How much water do you drink each day? _____ 8 ounce glasses
- Do you exercise regularly? Yes No

ACTIVITIES OF DAILY LIVING (Please check one for each item)

- | | | | |
|---------------------|--|---|-----------------------------------|
| Drive Automobile | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance | <input type="checkbox"/> Not Able |
| Take Medications | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance | <input type="checkbox"/> Not Able |
| Use telephone | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance | <input type="checkbox"/> Not Able |
| Care for Appearance | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Use Toilet | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Bath/Shower | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Dress Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Feed Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Walk | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Get in/out bed | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Housework | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Prepare Meals | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Handle Money | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Shop for Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |

MEDICARE (Only fill out if currently receiving Medicare)

- Have you ever received a kidney transplant? No Yes If yes, date Received _____
- Do you participate in a Dialysis Program? No Yes If yes, date Received _____
- Do you participate in a Black Lung program? No Yes
- Are services covered under a government program, such as a research grant? Yes No
- Are you entitled to any Veteran's Administration (VA) benefits? Yes No

Patient Signature _____ **Date** _____
(Or Legal Guardian/Power of Attorney)

Nurse Signature _____ **Date** _____



Chandler Regional Hospital

CHW

Patient Label