

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 _____

▪ WOUND HISTORY

Wound location: _____

When did you first notice the wound? _____

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

How did your wound start (wounding event)? Footwear Injury Burn Injury Radiation Injury Pressure Injury Surgical Incision Skin lesion such as pimple, bump, blister, bruise, etc. It just gradually appeared I don't know Trauma Injury not otherwise specified Other

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)
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you have diabetes: Do you take: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled How long have you had diabetes? _____ Do you test your blood sugar every day? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many times /day ____ What are your blood sugar testing results? Breakfast_____ Lunch_____ Dinner_____ Bedtime_____
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	

IMMUNIZATION RECORD

IMMUNIZATION	DATE RECEIVED
Tetanus Toxoid	
Annual Influenza (Flu Shot)	
Pneumococcal (Pneumonia)	

Staff only:

Referred for Flu vaccination – Date of referral: _____ Vaccination not available (summer months)

Referral location: _____

Referred for Pneumonia vaccination –

Date of referral: _____ Referral location: _____

Pediatric patients under age 14 only

IMMUNIZATION	DATE RECEIVED

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 _____

- Has anyone close to you tried to hurt or harm you recently? Yes, explain: _____
 No
- Do you feel uncomfortable with anyone in your family? Yes, explain: _____
 No
- Does anyone tell you that you give them too much trouble? Yes, explain: _____
 No
- Has anyone forced you do things that you didn't want to do? Yes, explain: _____
 No
- Do you feel that nobody wants you around? Yes, explain: _____
 No
- Who makes decisions about your life....like how you should live or where you should live? Yes, explain: _____
 No
- During the past week have you had any thoughts of harming yourself? Yes, explain: _____
 No

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

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

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)

Staff Only: ABNORMALITIES ADDRESSED BY RN

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

CURRENT HEALTH STATUS (Please check one for each item)

Energy Level Good Fair Poor

Physical Function Good Fair Poor

Social Functioning Good Fair Poor

Mental Health Good Fair Poor

Health Perception Good Fair Poor

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

Drive Automobile Completely Able Need Assistance Not Able

Take Medications Completely Able Need Assistance Not Able

Use telephone Completely Able Need Assistance Not Able

Care for Appearance Completely Able Needs Assistance Not Able

Use Toilet Completely Able Needs Assistance Not Able

Staff Only: Reviewed by Staff (See Medical Summary)

The Nutrition Screening Initiative Checklist

Read the statements below. Circle the number in the "yes" column for those that apply to you. You or the staff can then total your nutritional score at the bottom.

	YES
I have an illness or condition that made me change the kind and /or amount of food I eat.	2
I eat fewer than two meals per day.	3
I eat few fruits or vegetables, or milk products. <i>(Two cups of fruit, 2 1/2 cups of vegetables, and three cups of milk per day are recommended based on a 2,000-calories/day diet)</i>	2
I have three or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last six months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	_____
<i>These materials are developed and distributed by the Nutritional Screening Initiative, a project of: American Academy of Family Physicians; The American Dietetic Association; The National Council on the Aging, Inc.</i>	

Patient Signature

Date/Time: _____

(Or Legal Guardian/Power of Attorney)

Nurse Signature

Date/Time: _____