Date_____

GENERAL INFORMATION

Name_____ Home Phone_____

Address_____ Cell Phone _____

City_____ State_____ Zip_____

E-mail:_____

Date of Birth _____ Age _____ Sex _____

Do you live alone: ☐ No ☐ Yes Do you drive: ☐ No ☐ Yes

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_____

Do you have any of the following?

Advanced Directive: ☐Yes* ☐No Living Will: ☐Yes* ☐No Medical Power of Attorney: ☐Yes* ☐ No

Do Not Resuscitate: ☐Yes* ☐No

*Copy required to be in chart: Initials: _____Date/Time:_____/_____

Copy provided:☐: Initials:_____Date/Time:_____/_____

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)? ☐ Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Gradually Appeared ☐ Not Known ☐ Other Lesion ☐ Pimple ☐ Pressure ☐ Radiation Burn ☐ Surgical ☐ Thermal Burn ☐ Trauma

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PATIENT IDENTIFICATION
1 1/4" X 3"

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 tested positive for an antibiotic resistant organism (MRSA, VRE)? ☐ No ☐ Yes Date: _____

Have you tested positive for osteomyelitis (bone infection)? ☐ No ☐ Yes Date: _____

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: _____

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

	Yes	No		Yes	No
Cardiovascular			*Endocrine*		
Angina			Hyperthyroid		
Congestive Heart Failure			Hypothyroid		
Coronary Artery Disease			Diabetes		
Deep Vein Thrombosis			If Yes, for how long:		
Hypertension			Do you take: ○Insulin ○Oral Agents ○Diet Controlled		
Hypotension			Do you test your blood sugar every day? ○Yes How Often_____ ○No		
Myocardial Infarction					
Peripheral Arterial Disease			What are your usual blood sugar results:		
Peripheral Venous Disease			Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime: _____		
Stroke			*Eyes*		
Vasculitus			Cataracts		
Gastrointestinal			Diabetic Retinopathy		
Cirrhosis			Glaucoma		
Colitis			*Genitourinary*		
Crohn's Disease			Dialysis		
Hepatitis (Type: ____)			End Stage Renal Disease		
Neurological			*Hematologic/Lymphatic*		
Dementia			Anemia		
Epilepsy			Leukocytopenia		
History of Seizures			Lymphedema		
Neuropathy			Sickle Cell Disease		
Paraplegia			Thrombocytopenia		
Quadriplegia			*Immunological*		
Pulmonary			Lupus		
Emphysema			Raynaud's Syndrome		
Pulmonary Embolism			Scleroderma		
Asthma			*Integumentary*		
Chronic Obstructive Pulmonary Disease			History of Burn		
Collapsed Lung/Pneumothorax			*Oncological*		
Use Supplemental Oxygen			History of Chemotherapy Type:		
Musculoskeletal			History of Radiation		
Gout			*Psychiatric*		
Osteoarthritis			Confinement Anxiety		
Rheumatoid Arthritis			Depression		
Ear/Nose/Mouth/Throat			*Reproductive*		
Chronic Sinus problems/congestion			Miscarriage		
Middle ear problems					
Immunizations: When was your last tetanus shot?			*Any implantable devices?*		

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HOSPITALIZATION/SURGERY HISTORY (*Please list all past hospitalizations)*

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

FAMILY MEDICAL HISTORY					
Please indicate with a checkmark if any of your family members have/had this condition.	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hereditary Spherocytosis					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Thyroid					
Tuberculosis					

NOTES:

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center for your first visit.

Person Completing Form:

_____Date/Time:_____

_

(Signature/Relationship to Patient)

Reviewed By:

_____

RN Signature Date/Time

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