GENERAL INFORMATION		DATE:	
Name		Home Phone	
Address		Cell Phone	
City		State	Zip
▲ E-mail	Date of Birth	Age	Sex

SOCIAL HISTORY

Do you live alone: □ No □ Yes	Do you drive: □No □ Yes	Employed: □ No □ Yes
What is the highest school grade you completed? □ 1-6 □ 7-9 □ 10 □ 11 □ 12 □ Some college □ College graduate		
Marital Status: □ Separated □ Divorced □ Married □ Single □ Widowed		
Do you smoke: □ No □ Yes If Yes, for how many years:	How many packs per day:	If quit, when:
Do you drink alcohol: □ No History □ Prior History □ Current History		Type:
Do you use recreational drugs: □ No □ Yes If Yes, amount:		Type:
Caffeine Use: □ No □ Yes If Yes, for how many years:	How many cups per day:	
Financial Concerns: □ Yes □ No	Food/Clothing/Shelter Needs: □ Yes □ No	
Support System Intact: □ Yes □ No	Transportation Concerns: □ Yes □ No	

EMERGENCY CONTACT INFORMATION

Name	Home Phone
Relationship	Cell Phone

What physician suggested you visit the Wound Care Center®?

Name	Specialty	Phone	
Address	City	State	Zip

Who is your primary physician?

Name	Specialty	Phone	
Address	City	State	Zip

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

Do you have any of the following?

Advance Directive: □ Yes* □ No	Living Will: □ Yes* □ No	Medical Power of Attorney: □ Yes* □ No	Do Not Resuscitate: □ Yes* □ No

*Copy required for chart. Requested by: _____ Date: _____ Time: _____
□ Copy provided. Signature: _____ Date: _____ Time: _____

Name of Person Completing Form: _____ Relationship to Patient: _____
Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____
Reviewed By: _____ Date: _____ Time: _____

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PATIENT LABEL

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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? □Bite □ Blister □ Bruise □ Bump □ Chemical Burn □ Footwear □ Frostbite □ Gradually Appeared □ Not Known □ Other Lesion □ Pimple □ Pressure □ Radiation Burn □ Surgical □ Thermal Burn □ Trauma		
How have you been treating your wound until now?		
Have you had any lab work done in the past month? ☐ No ☐ Yes	If Yes, Who Ordered?	
Have you ever had bacteria that resisted antibiotics)? ☐ No ☐ Yes		If Yes, Date:
Have you ever had a bone infection? ☐ No ☐ Yes		If Yes, Date:
Have you had any tests for blood flow in your legs? ☐ No ☐ Yes		If Yes, Date:
If Yes, Where was it done:	Who ordered?	
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other		

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

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis/Crohn's (Bowel problems)		
Chronic Sinus problems/congestion			Hepatitis (Type:)		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type:_____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)					
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia/bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial Infarction (Heart attack)					
Peripheral Arterial Disease (Problem with blood flow in your legs)			Peripheral Venous Disease (Problem with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)			Phlebitis (Inflammation of the veins in your legs)		

Name of Person Completing Form:_____Relationship to Patient:_____
Signature: _____Date: _____Time: _____

Reviewed By: _____Date:_____Time:_____
Reviewed By: _____Date:_____Time: _____

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FAMILY MEDICAL HISTORY (*Please indicate with a checkmark if any of your family members have/had this condition)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

HOSPITALIZATION/SURGERY HISTORY (*Please list all)*

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

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.

For Healthcare Practitioner Use Only

NOTES:

Name of Person Completing Form:_____Relationship to Patient:_____
Signature: _____Date: _____Time: _____

Reviewed By:_____Date:_____Time:_____
Reviewed By: _____Date:_____Time: _____

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