

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

**SOCIAL HISTORY**

Do you live alone: <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you drive: <input type="checkbox"/> No <input type="checkbox"/> Yes	Employed: <input type="checkbox"/> No <input type="checkbox"/> Yes
What is the highest school grade you completed? <input type="checkbox"/> 1-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> Some college <input type="checkbox"/> College graduate		
Marital Status: <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Do you smoke: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, for how many years: _____ How many packs per day: _____ If quit, when: _____		
Do you drink alcohol: <input type="checkbox"/> No History <input type="checkbox"/> Prior History <input type="checkbox"/> Current History _____ Type: _____		
Do you use recreational drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, amount: _____ Type: _____		
Caffeine Use: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, for how many years: _____ How many cups per day: _____		
Financial Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No		Food/Clothing/Shelter Needs: <input type="checkbox"/> Yes <input type="checkbox"/> No
Support System Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No		Transportation Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Living Will: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Medical Power of Attorney: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Do Not Resuscitate: <input type="checkbox"/> Yes* <input type="checkbox"/> No
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\*Copy required for chart. Requested by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Copy provided. Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

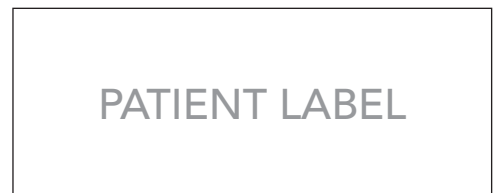
Name of Person Completing Form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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**PATIENT HISTORY**



**Do Not Place Below This Line.**



**WOUND HISTORY**

Wound location:	
When did you first notice the wound?	Has it ever healed and then re-opened? <input type="checkbox"/> Yes <input type="checkbox"/> No
How did your wound start? <input type="checkbox"/> Bite <input type="checkbox"/> Blister <input type="checkbox"/> Bruise <input type="checkbox"/> Bump <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Footwear <input type="checkbox"/> Frostbite <input type="checkbox"/> Gradually Appeared <input type="checkbox"/> Not Known <input type="checkbox"/> Other Lesion <input type="checkbox"/> Pimple <input type="checkbox"/> Pressure <input type="checkbox"/> Radiation Burn <input type="checkbox"/> Surgical <input type="checkbox"/> Thermal Burn <input type="checkbox"/> Trauma	
How have you been treating your wound until now?	
Have you had any lab work done in the past month? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Who Ordered?
Have you ever had bacteria that resisted antibiotics? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Date:
Have you ever had a bone infection? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Date:
Have you had any tests for blood flow in your legs? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Date:
If Yes, Where was it done:	Who ordered?
Have you had any other problems with your wound? <input type="checkbox"/> Infection <input type="checkbox"/> Swelling <input type="checkbox"/> 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: \_\_\_\_\_



Do Not Place Below This Line.



**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: \_\_\_\_\_  
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