Patient Label

PATIENT HISTORY

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 □ Yes If Yes, amount: Type:		
Do you use recreational drugs: □ No □ Yes If Yes, amount: Type:		

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: _____

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	

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

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

PATIENT HISTORY

How have you been treating your wound until now?		
WOUND HISTORY (continued) 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
Chest pain			Middle ear problems		
Heart disease			Hyperthyroid		
Blood clot in leg			Hypothyroid		
High blood pressure			Cataracts		
Low blood pressure			Eye disease due to diabetes		
Heart attack			Eye disease		
Problem with blood flow in your legs			On Dialysis		
Stroke			Kidney disease		
Problem with blood vessels in your legs			Low red blood cell count		
Liver problems			Low white blood cell count		
Bowel problems			Low platelet count		
Hepatitis (Type:)			Swelling of arms or legs		
Memory loss that gets worse over time			Problem with your red blood cells		
Epilepsy			Problem with your immune system		
Seizures			Problem with blood flow to your fingers or toes		
Can't move arms or legs			History of Burn		
Can't move arms and legs			History of Chemotherapy		
Lung disease			Type:		
Blood clot in lung			History of Radiation therapy		
Asthma			Fear about being in a closed space		
Collapsed Lung			Depression		
Use Supplemental Oxygen			Miscarriage		
Gout			Any device placed inside your body?		
Pain in bones or joints			When was your last tetanus shot?		
Swelling of joints			Chronic Sinus problems/congestion		
High blood sugar (diabetes)					

If Yes, for how long:_____ Do you take: □ Insulin □ Medicine by mouth
□ Controlled by my diet

Do you test your blood sugar every day? □ No □ Yes - How Often_____
What are your usual blood sugar results: Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime: _____

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

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

Patient Label

PATIENT HISTORY

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.

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

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