(Patient Label / Addressograph)

Patient History (Page 1 of 3)

General Information **Date:** _____

▲ Name: _____ ▲ Primary Phone: _____

▲ Address: _____ Secondary Phone: _____

▲ City: _____ State: _____ Zip: _____

▲ Email: _____ ▲ 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 **Spouse Name:** _____

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

How will you travel to the Center: ☐ Car ☐ Ambulance ☐ Ambulette ☐ Public ☐ Other: _____

Emergency Contact Information

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

▲ What provider referred you to the Wound Care Center®?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

▲ Who is your primary provider?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

▲ If your provider did not refer you, how did you hear about our Wound Care Center®?

☐ Self-referral ☐ Extended Care Facility (SNF, LTAC, Nursing Home) ☐ Advertising ☐ Former Patient ☐ Home Health

☐ Friend / Family ☐ Recently discharged from this hospital ☐ Recently discharged from another hospital ☐ Other

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?

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: 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? ☐ No ☐ Yes

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: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

Patient History (Page 2 of 3)

Patient's Medical History *(Please check Yes or No for each Item.)*

HISTORY OF:	Yes	No	HISTORY OF:	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)			Received Radiation		
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 Venous Disease (Problem with blood vessels in your legs)		
Peripheral Arterial Disease (Problem with blood flow in your legs)			Phlebitis (Inflammation of the veins in your legs)		
Vasculitis (Inflammation of your blood vessels)					

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

Continued on Next Page . . .

Name of Person Completing Form: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

(Patient Label / Addressograph)

Patient History (Page 3 of 3)

Continued from Previous Page . . .

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 Provider Use Only

NOTES

Name of Person Completing Form: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

PAP Form-03 • Rev 04/17
Healogics Form: Patient History_C312F • Revised (1/2017)
To Order Call Pic•A•Poc @ (631) 981-2094