 **WOUND HEALING CENTER**

**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT CAUSED YOUR WOUND? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF INJURY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT TYPE OF DRESSING HAVE YOU BEEN USING ON YOUR WOUND?**

**­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHO HAS BEEN TREATING YOUR WOUND?**

|  |  |  |
| --- | --- | --- |
| **Self** | **YES** | **NO** |
| **PRIMARY CARE PHYSICIAN** | **YES** | **NO** |
| **URGENT CARE** | **YES** | **NO** |
| **ER**  | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| **CULTURE** | **YES** | **NO** |
| **ANTIBIOTICS** | **YES** | **NO** |
| **MRI** | **YES** | **NO** |
| **X-RAY** | **YES** | **NO** |

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

**LOCAL PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE OR ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| **DISEASE/CONDITION** | **YES** | **NO** |
| **ASTHMA** |  |  |
|  |  |  |
| **CANCER (TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  |  |
|  |  |  |
| **DIABETES (TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  |  |
|  |  |  |
| **EMPHYSEMA/COPD** |  |  |
|  |  |  |
| **HEART DISEASE** |  |  |
|  |  |  |
| **HIGH CHOLESTEROL** |  |  |
|  |  |  |
| **THYROID DISEASE** |  |  |
|  |  |  |
| **KIDNEY DISEASE** |  |  |
|  |  |  |
| **AUTO IMMUNE DISEASE (TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  |  |
|  |  |  |
| **VENOUS INSUFFICIENCY** |  |  |
|  |  |  |
| **OTHER** |  |  |

**SURGICAL HISTORY**

|  |  |
| --- | --- |
| **TYPE: (SPECIFY LEFT OR RIGHT)** | **DATE** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**MEDICATIONS**

**IF YOU HAVE A LIST OF MEDICATIONS YOU DO NOT HAVE TO FILL IN THE BOX BELOW. PLEASE GIVE LIST TO OFFICE COORDINATOR OR NURSE**

**(REMEMBER TO INCLUDE HERBAL SUPPLEMENTS AND OTHER OVER THE COUNTER MEDICATIONS)**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSE/FREQUENCY** | **MEDICATION** | **DOSE/FREQUENCY** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**FAMILY HISTORY**

**(PLEASE INDICATE WITH A CHECKMARK IF ANY FAMILY MEMBERS HAVE/HAD THIS CONDITION)**

|  |  |  |  |
| --- | --- | --- | --- |
| **CONDITION** | MOTHER | FATHER | SIBLINGS |
| CANCER |  |  |  |
| DIABETES |  |  |  |
| HEART DISEASE  |  |  |  |
| HYPERTENSION |  |  |  |
| LUNG DISEASE |  |  |  |

**SOCIAL HISTORY (PLEASE CIRCLE YOUR ANSWERS)**

**I LIVE:** ALONE WITH FAMILY ASSISTED LIVING SKILLED NURSING FACILITY

**HIGHEST LEVEL OF**

**EDUCATION?** HIGH SCHOOL COLLEGE OTHER

**SMOKING STATUS** NEVER FORMER (YEAR QUIT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) CURRENT

**ALCOHOL** YES WHAT TYPE: BEER WINE LIQUOR FREQUENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NO

**SOCIAL HISTORY CONTINUED (PLEASE CIRCLE YOUR ANSWERS)**

**DO YOU FEEL SAFE AT HOME?** YES NO

**HAS ANYONE INJURED YOU IN THE PAST YEAR?** YES NO

**ANY FEELINGS OF DEPRESSION, HOPELESSNESS?** YES NO

**IN YOUR LIFETIME, HAVE YOU EVER ATTEMPTED SUICIDE?** YES NO

**EMOTIONAL SUPPORT AVAILABLE?** YES NO

**ANY RELIGIOUS/CULTURAL CONCERNS THAT MAY AFFECT YOUR CARE?** YES NO

**DO YOU RECEIVE COMFORT FROM A SPIRITUAL PRACTICE**? YES IDENTIFY TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NO

**PHYSICAL ASSESSMENT**

**HEIGHT** FT: \_\_\_\_ IN: \_\_\_\_\_  **WEIGHT:** \_\_\_\_\_\_\_\_\_\_\_

**GLASSES?** YES NO **HEARING AIDS?** YES NO

**APPETITE** GOOD FAIR POOR

**HOME DIET** REGULAR DIET SPECIAL DIET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY UNINTENDED WEIGHT LOSS IN PAST 3 MONTHS?** YES NO

**ACTIVITIES OF DAILY LIVING: DRESSING, BATHING, TOILETING, EATING, AMBULATION**

 INDEPENDENT PARTIAL ASSISTANCE REQUIRE FULL ASSISTANCE

**EMAIL FORM TO** **woundcare.outpatient@nchmd.org**

**OR BRING THIS FORM TO YOUR FIRST APPOINTMENT.**