

## PATIENT HISTORY

Date \_\_\_\_\_

### ▪ GENERAL INFORMATION

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

### ***Emergency Contact Information***

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Cell Phone \_\_\_\_\_

### ***What physician suggested you visit the Wound Healing Center?***

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### ***Who is your primary physician?***

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***Home Health Care/Nursing Home*** \_\_\_\_\_ Phone \_\_\_\_\_

***Pharmacy*** \_\_\_\_\_ Phone \_\_\_\_\_

***Have you ever been a patient at Bethesda?***  Yes  No

### ▪ WOUND HISTORY

Wound location: \_\_\_\_\_

When did you first notice the wound? \_\_\_\_\_

How did your wound start? \_\_\_\_\_

Has it ever healed and then re-opened?  Yes  No

How have you been treating your wound until now? \_\_\_\_\_

Have you had any lab work done in the past month?  No  Yes, Who Ordered \_\_\_\_\_

Have you had any tests for circulation on your legs?  No  Yes, Where done \_\_\_\_\_

Who ordered \_\_\_\_\_

Have you had any other problems associated with your wound? (Please check)

Infection  Swelling  Other: \_\_\_\_\_

Patient Label

**MEDICAL HISTORY** Please check Yes or No for each item

	PATIENT		MANAGING PHYSICIAN	FAMILY		EXPLAIN (Who, Age)
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If you have diabetes:</b> Do you take: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled How long have you had diabetes? _____ Do you test your blood sugar every day? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many times /day ____ What are your blood sugar testing results? Breakfast_____ Lunch_____ Dinner_____ Bedtime_____
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis/Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Convulsion/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**HOSPITALIZATION/SURGERY HISTORY** (Please list all past hospitalizations)

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

**Staff Only: Reviewed by Staff (See Medical Summary)**



**SOCIAL HISTORY** (Please check one for each item)

**Marital Status:**  Single  Married  Separated  Divorced  Widowed

**Tobacco Use:**  Never  Previously, but quit \_\_\_\_\_ years ago Current packs per day \_\_\_\_\_

**Alcohol Use:**  Never  Rarely  Moderate  Daily

**Drug Use:**  Never Type/Frequency \_\_\_\_\_

**Caffeine Use:**  Never Type/Frequency \_\_\_\_\_

**SYSTEM REVIEW** Please check Yes or No for each item

**GENERAL SYMPTOMS**

Good general health lately  Yes  No

Fatigue  Yes  No

Height \_\_\_\_\_ Weight: \_\_\_\_\_

**EYES**

Glaucoma  Yes  No

Cataracts  Yes  No

**EARS/NOSE/MOUTH/THROAT**

Chronic sinus problems or rhinitis  Yes  No

Sore throat or mouth sores  Yes  No

Swollen glands in neck  Yes  No

**GASTROINTESTINAL**

Frequent diarrhea  Yes  No

Constipation  Yes  No

Blood in stool  Yes  No

**INTEGUMENTARY (Skin)**

Bleeding or bruising tendency  Yes  No

Change in mole  Yes  No

**MUSCULOSKELETAL**

Joint pain  Yes  No

Joint stiffness  Yes  No

Weakness of muscles or joints  Yes  No

Back Pain  Yes  No

Osteoarthritis  Yes  No

**NEUROLOGICAL**

Frequent /recurring headaches  Yes  No

Light headed or dizzy  Yes  No

**Staff Only: Reviewed by Staff (See Medical Summary)**

**CARDIOVASCULAR**

Chest Pain  Yes  No

Pacemaker:  Yes  No

If yes, Manufacturer \_\_\_\_\_

**RESPIRATORY**

Chronic or frequent coughs  Yes  No

Spitting up blood  Yes  No

Shortness of breath/Sleep apnea  Yes  No

Asthma/Emphysema/TB  Yes  No

**PSYCHIATRIC**

Depression  Yes  No

Claustrophobia  Yes  No

**ENDOCRINE/HEPATIC**

Thyroid disease  Yes  No

Excessive thirst/urination  Yes  No

Heat/cold intolerance  Yes  No

Hepatitis  Yes  No

**HEMATOLOGIC/LYMPHATIC**

Anemia  Yes  No

Human Immunodeficiency Virus  Yes  No

**GENITOURINARY**

Frequent urination  Yes  No

Blood in urine  Yes  No

Incontinence/dribbling  Yes  No

Kidney failure/ Dialysis  Yes  No

Kidney transplant  Yes  No

**Staff Only: ABNORMALITIES ADDRESSED BY RN**

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**CURRENT HEALTH STATUS** (Please check one for each item)

Energy Level	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Physical Function	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Social Functioning	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Mental Health	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Health Perception	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

**NUTRITION PROFILE** Please check Yes or No for each item

Difficulty chewing or swallowing?  Yes  No

Do you need assistance with eating?  Yes  No

Have you had a large weight loss?  Yes  No

Have you had a large weight gain?  Yes  No

If yes, \_\_\_\_\_pounds in \_\_\_\_\_months. Reason, if known \_\_\_\_\_  Yes  No

Special diet?  Yes  No

Food allergies?  Yes  No

Are you involved in weight loss program?  Yes  No

Weight Loss Medications: \_\_\_\_\_

How many meals do you eat each day? \_\_\_\_\_

Appetite:  Good  Fair  Poor (Please check one)

Do you take nutritional supplements?  Yes  No

How much water do you drink each day? \_\_\_\_\_ 8 ounce glasses  Yes  No

Do you exercise regularly?  Yes  No

**ACTIVITIES OF DAILY LIVING** (Please check one for each item)

- |                     |  |   |                                   |
|---------------------|--|---|-----------------------------------|
| Drive Automobile    | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance  | <input type="checkbox"/> Not Able |
| Take Medications    | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance  | <input type="checkbox"/> Not Able |
| Use telephone       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Need Assistance  | <input type="checkbox"/> Not Able |
| Care for Appearance | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Use Toilet          | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Bath/Shower         | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Dress Self          | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Feed Self           | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Walk                | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Get in/out bed      | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Housework           | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Prepare Meals       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Handle Money        | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Shop for Self       | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |

**MEDICARE** (Only fill out if currently receiving Medicare)

- Have you ever received a kidney transplant?  No  Yes If yes, date Received \_\_\_\_\_
- Do you participate in a Dialysis Program?  No  Yes If yes, date Received \_\_\_\_\_
- Do you participate in a Black Lung program?  No  Yes
- Are services covered under a government program, such as a research grant?  Yes  No
- Are you entitled to any Veteran's Administration (VA) benefits?  Yes  No

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Or Legal Guardian/Power of Attorney)

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_