PRESBYTERIAN

Wound Center History Form (Page 1)

How do you prefer to be addressed/ what name do you prefer? _____

How did your wound start? (injury, surgery, pressure, etc.) _____

Has this occurred before? □ No □ Yes, describe: _____

Has it changed since you first noticed it? □ No □ Yes, describe: _____

What is being done to take care of it? _____

Is someone helping to take care of it? _____ How often is care done?_____

What have you found that helps? _____

What didn't help, or made it worse? _____

Have you been given antibiotics? □ No □ Yes Are you still on them? □ No □ Yes

Have you ever been told you have MRSA? □ No □ Yes

Where do you get your supplies? _____

What type of work/activities/exercise do you do?_____

What symptoms bother you? _____

What is your goal? _____

Is there any other information that will be helpful for us to know? _____

_____

Are you having WOUND pain? □ No □ Yes, describe: _____

Please rate your pain on a scale from 0-10 with zero being no pain, and 10 being the worst pain imaginable.

What is it now? _____ At its worst? _____ At its best? _____ Acceptable level? _____

When does the pain occur? _____ How long does it last? _____

Does anything relieve the pain? _____ Make it worse? _____Is there

I live (circle one)
alone
with family/friends
care facility (type/name) _____
other:_____

Who is your primary care provider:

_____

What other tests have been done or healthcare providers you have seen for this issue:

Do you smoke or use tobacco? □ No □ Yes, how much? _____
Did you previously smoke? □ No □ Yes, when did you quit?_____

Do you drink alcohol? □ No □ Yes, how much? _____

Are you on a special diet? □ No □ Yes, what type? _____

Patient Identification

Patient Signature: _____

Reviewed by: _____ Date: _____

PRESBYTERIAN

Wound Center History Form (Page 2)

Please circle the number in the "Yes" column for those that apply to you	**Yes**
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits and vegetables or milk products.	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
Total	

0-2 good, 3-5 you are at moderate nutritional risk, 6 or more you are at high nutritional risk

General History: please check "Yes" if these apply to you.

	Yes		**Yes**		**Yes**
Fever or chills		Trouble with walking		Nausea/vomiting/diarrhea	
Pain even without wound		Amputation(s)		Incontinence or ostomy	
Weight loss		Bone infection(s)		Stomach ulcers	
Skin cancers		Arthritis		Hepatitis and/ or cirrhosis	
Swelling		Wound limits movement		Blood clots (DVT)	
Poor circulation		Get short of breath		Bleeding problems	
Heart Failure		Use oxygen: how much?		Thyroid problems	
Coronary Artery Disease		Numbness		Immune deficiency	
High blood pressure		Paralysis or weakness		Transplanted organ	
Heart attack		Stroke		Previous surgery	
Joint replacement or other implant		Dialysis: *What is your schedule?*		Other *(explain):*	

Do you have Diabetes? ☐ **No** ☐ **Yes** • Last A1c result:_____ • Have you seen a diabetic educator? ☐ **No** ☐ **Yes** • Do you have diabetic shoes? ☐ **No** ☐ **Yes** • Do you see a podiatrist? ☐ **No** ☐ **Yes** What do your blood sugars run at home? _____	**If you are in a wheelchair:** • When was your last wheelchair evaluation? _____ • What kind of cushion do you have? _____ How often do you change position?
Have you had **radiation** treatments (not x-rays)? ☐ No ☐ Yes What body location? _____	Are you currently receiving **Chemotherapy**? ☐ No ☐ Yes
Have you ever been asked to wear compression stockings? ☐ **No** ☐ **Yes** • When do you wear them: _____ • When was your last pair purchased? Where?	
How do you learn best? ☐ **Reading** ☐ **Listening** ☐ **Watching** ☐ **Other:**	
Do you have any specific customs, wishes or beliefs that might affect care? ☐ No ☐ Yes	

Patient Signature: _____

Reviewed by: _____ Date: _____

Patient Identification