PRESBYTERIAN

Wound Center History Form – Ostomy Patient Post-Op (Page 1)

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

What type of ostomy do you have: _____ Date of surgery _____

Reason for the ostomy surgery? _____

Are you experiencing problems? ☐ No ☐ Yes, please describe: _____

What type of pouching system are you in? ☐ 1-piece ☐ 2-piece ☐ Unsure

Brand of ostomy pouch, if known: _____ Supply Number: _____

Do you change the ostomy appliance yourself or have assistance? ☐ Self ☐ Assistance

If assisted, who helps you? _____

Do you have home health care? ☐ Yes ☐ No

If yes, what is the name of the company and nurse? _____

How often do you have to change the ostomy appliance? _____

Are you using any of the following? ☐ Paste ☐ Skin barrier ☐ Powder ☐ Belt

Any additional products you are using: _____

Where do you get your supplies? _____

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

What symptoms bother you? _____

Are you having pain around the ostomy? ☐ 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? _____

Does anything worsen the pain? _____

What is your goal? _____

Do you smoke or use tobacco? ☐ No ☐ Yes, how much? _____

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

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

_____

Patient Identification

Patient Signature: _____

Reviewed by: _____ Date: _____

PRESBYTERIAN

Wound Center History Form – Ostomy Patient Post-Op (Page 2)

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
1. I feel that I have recovered from my stoma operation					
2. I don't like to touch or see my stoma**					
3. I have a meaningful life even with a stoma					
4. I enjoy food and drinks as much as I did before my stoma					
5. My stoma inhibits me from having a proper bath or shower**					
6. I sleep well without worrying about my stoma					
7. Because of my stoma I feel I am no longer in control of my life**					
8. I am reluctant to mix socially since having my stoma**					
9. I have now accepted my stoma as part of my body					
10. I cannot get over the shock of having a stoma**					
11. Because of my stoma I limit my range of activities**					
12. Because of my stoma I feel that I will always be a patient**					
13. I am always conscious that my stoma may leak, smell or be noisy**					
14. I have accepted the changes in my appearance which were caused by the stoma.					
15. I am grateful that the stoma has given me a new lease of life					
16. Caring for my stoma is difficult**					
17. I feel that I am less sexually attractive because of my stoma**					
18. I feel angry about having a stoma**					
19. Despite my stoma I feel I have a rewarding life					
20. I will be able to manage my stoma in the future					
21. I am always anxious about my stoma**					
22. With my stoma I feel that my life-threatening experience has passed					
23. I can engage in a variety of activities despite having a stoma					

** **Reverse scored**

Have you had **radiation** treatments (not x-rays)? ☐ **No** ☐ **Yes**
What body location?

Are you currently receiving **Chemotherapy**? ☐ **No** ☐ **Yes**

Do you have any specific customs, wishes or beliefs that might affect care? ☐ **No** ☐ **Yes**

Patient Signature: _____

Reviewed by: _____ Date: _____

Patient Identification