Admit Date:		Wound Care Physician:
Height:	Weight:	▲ Gender: ☐ Male ☐ Female

▲ **Ethnicity:** ☐ African American ☐ Asian or Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknown

☐ **Unable to obtain a comprehensive history due to patient's condition**

WOUND INFORMATION:

▲ **How did your wound(s) start?**

☐ Injury: Describe ☐ Surgical Procedure: Describe

☐ Appeared Gradually ☐ Other:

What treatments have been used on your wound?

☐ Whirlpool ☐ Hyperbaric Oxygen
☐ Total Contact Casting ☐ Soaks
☐ Saline Dressing ☐ Compression wrap/Stockings
☐ Topical Gel/Ointment ☐ Other:

▲ Has your wound ever completely healed? ☐ Yes ☐ No
Has your wound healed while being treated at this center?
☐ Yes ☐ No
▲ Has amputation been recommended for this wound?
☐ Yes ☐ No

▲ **Have you ever been treated for a bone infection? ☐ No ☐ Yes If yes, when and what treatment?**

▲ **Do you have circulation problems in your legs? ☐ No ☐ Yes If yes, have you ever had tests for circulation? ☐ No ☐ Yes**
Where? _____ **Date?** _____

What is your goal for seeking treatment at this center?

▲ **May we contact/send communications to your primary and referring physician?** ☐ Yes ☐ No

Can You or Do You –

Walk without assistance? ☐ Yes ☐ No Use a cane? ☐ Yes ☐ No Do you live alone? ☐ Yes ☐ No
Walk with assistance? ☐ Yes ☐ No Use a brace? ☐ Yes ☐ No Use crutches? ☐ Yes ☐ No
Bed/wheelchair only? ☐ Yes ☐ No

Do You Need Help With – Shopping? ☐ Yes ☐ No Cooking? ☐ Yes ☐ No Personal Care? ☐ Yes ☐ No

Social History

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Language spoken at home? English, other _____ Interpreter needed? ☐ Yes ☐ No

Smoking: ☐ No ☐ Yes If yes, How long? Years How much? Packs per day If quit when?

Alcohol: ☐ No ☐ Yes If yes, Amount per Day: Type:

Recreational Drugs ☐ No ☐ Yes Type: Retired? ☐ Yes ☐ No Employer _____

Are there any Religious/Cultural Preferences that could affect your care? ☐ No ☐ Yes
If "yes" – explain:

▲ **Recent Tests or X-rays done before coming to the Wound Center?** ☐ Yes ☐ No
If yes, type of test and when it was done: _____
Immunization: When was your last tetanus shot? _____
Have you received a Flu Shot? ☐ Yes if yes, when? _____
Have you received a Pneumonia shot? ☐ Yes if yes, when?_____ ☐ No, for flu or pneumonia, refer to Primary Care Physician

▲ **Do You Have Diabetes?** ☐ Yes ☐ No	**Kidney Dialysis** ☐ Yes ☐ No	**List Previous Surgeries/Year**
How long have you had diabetes?	How Long?	
Do you test your blood sugar?	Frequency?	
If yes, how often?	Days of the Week:	
What do your blood sugars usually run?	Shunt Location?	
	Shunt Type?	
History of Cancer? ☐ No ☐ Yes If yes, Type		
▲ **Received Radiation?** ☐ No ☐ Yes If yes, Where?		
Received Chemotharapy? ☐ No ☐ Yes If yes, Where?		

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PATIENT IDENTIFICATION

Patient History - RWHC

PAST / CURRENT MEDICAL HISTORY
☑ Check **SELF** for those that you have experienced in your life or have right now and explain
☑ Check **FH** (Family History), *if it applied to immediate family member (siblings, parents, grandparents)*

SELF	FH	Cardiac / Vascular History
		▲ **Congestive Heart Failure**
		▲ **Coronary Artery Disease**
		▲ **Peripheral Vascular Disorder**
		Chest pain/Palpitations
		High Blood Pressure
		Heart Attack
		Problem Legs/Feet
		Poor Circulation
		Pain in Legs
		Blood clots
		Pacemaker

SELF	FH	Gastrointestinal History
		▲ **End stage renal**
		▲ **Incontinence** (bladder/bowel difficulty)
		Trouble swallowing
		Reflux disease
		Nausea/Vomiting/Diarrhea
		Inflammatory bowel
		Celiac Disease

SELF	FH	Neurological History
		Paralysis
		Tremors
		Seizure
		Stroke
		Numbness (location)
		Head/Brain Trauma

SELF	FH	Other Conditions
		▲ **Diabetes**
		History of infections, bone, skin, other
		Immune Deficiency
		Lupus
		Scleroderma
		Cellulitis
		Thyroid Problems
		Jaundice / Hepatitis

SELF	FH	Pulmonary History
		▲ **Smoking**
		▲ **COPD** (Chronic Obstructive Pulmonary Disease)
		Emphysema
		Shortness of Breah
		Asthma
		Collapsed Lung
		Cough/Wheezin
		Tuberculosis
		Recent Lung/Virus Infection
		Oxygen use

SELF	FH	Neuromuscular / Orthopedic History
		Broken bones
		Leg or Foot Deformity
		Weakness

SELF	FH	Prosthetics
		Implants:
		Eye
		Breast
		Arm Leg
		Knee Joint Hip Joint
		Dentures, type
		Other implantable devices?

SELF	FH	Other Conditions
		▲ **Malnutrition**
		Low Blood Count
		Anxiety/Panic/Claustrophobia
		Problems with ears
		Eye problems
		Cataract
		Burns
		Sickle Cell Anemia

Caregiver: ☐ No ☐ Yes If yes,
Name: _____
Phone: _____ Relationship:
Are you currently receiving Home Care? ☐ No ☐ Yes
If yes, Agency Name: _____
Phone #: _____ Nurse: _____

SIGNATURE OF PERSON COMPLETING FORM: _____
(Signature/relationship to Patient) **Date**

Reviewed by: _____ _____
RN Signature **Date/Time** **Physician Signature** **Date/Time**

RH5715

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