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 Naples Community Hospital? ☐ ***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: _____

MEDICAL HISTORY Please check Yes or No for each item

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

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

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

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

ALLERGIES (Please list all known allergies and reactions)

ALLERGEN	REACTION

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

MEDICATION (*Please list all medicines you are currently taking. Include over the counter, herbal supplements and vitamins*)

MEDICATION	AMOUNT	HOW OFTEN

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

IMMUNIZATION RECORD

IMMUNIZATION	DATE RECEIVED
Tetanus Toxoid	

Pediatric patients under age 14 only

IMMUNIZATION	DATE RECEIVED

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

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

☐ ***Staff Only: ABNORMALITIES ADDRESSED BY RN***

_____

_____

_____

_____

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

Energy Level	☐ Good	☐ Fair	☐ Poor
Physical Function	☐ Good	☐ Fair	☐ Poor
Social Functioning	☐ Good	☐ Fair	☐ Poor
Mental Health	☐ Good	☐ Fair	☐ Poor
Health Perception	☐ Good	☐ Fair	☐ 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? 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 Do you exercise regularly?	☐ Yes	☐ No

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

Drive Automobile	☐ Completely Able	☐ Need Assistance	☐ Not Able
Take Medications	☐ Completely Able	☐ Need Assistance	☐ Not Able
Use telephone	☐ Completely Able	☐ Need Assistance	☐ Not Able
Care for Appearance	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Use Toilet	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Bath/Shower	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Dress Self	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Feed Self	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Walk	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Get in/out bed	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Housework	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Prepare Meals	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Handle Money	☐ Completely Able	☐ Needs Assistance	☐ Not Able
Shop for Self	☐ Completely Able	☐ Needs Assistance	☐ 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_____