Wound Care & Hyperbaric Center

Patient Name ____ DOB __________________________________

Physical Address ____

City, State, Zip ____

Home Phone _______________________________________ Mobile Phone ________________________________

Social Security No __________________________________ Sex: Male Female

Employer ____

Position ____ Work Phone _________________________________

Emergency Contact ____

Phone ____ Relation ____________________________________

Physician Information

Referring Physician ________________________________ Phone _______________________________________

Primary Physician __________________________________ Phone _______________________________________

Podiatry ____ Phone _______________________________________

Orthopedist ______________________________________ Phone _______________________________________

Cardiology _______________________________________ Phone _______________________________________

Home Health

Home Health Agency ________________________________ Phone _______________________________________

Pharmacy Information

Pharmacy ____ Phone _______________________________________

Pharmacy street, city ____

Insurance Information (primary)

Primary Insurance ____

Subscriber _______________________________________ Subscriber Date of Birth ________________________

Policy No ____ Group No ____________________________________

Insurance Information (secondary)

Primary Insurance ____

Subscriber _______________________________________ Subscriber Date of Birth ________________________

Policy No ____ Group No ____________________________________

Medical History (please circle when applicable)

Personal

What is your height? ______________________________________

What is your weight? ______________________________________

If diabetic, what is your blood sugar today? ____________________________

Marital status? Single Married Divorced Widow/widower

Living conditions? Alone With family Nursing Facility

Do you have family or friend who assists with your care? No Yes Home Health

Do you consume alcohol? Never 2 to 4 a month 2 to 4 a week 1 to 2 a day Other __________________

Do you smoke? No Yes If yes, how many packs per day? ____ If no, former smoker? No Yes

Do you use recreational drugs? No Yes

Pain

Are you currently having pain? No Yes

Where is the pain located? ____

Is your pain? Worsening Stable Improving

Is your pain? Occasional Intermittent Continuous

How long have you had your pain? ____

Describe your pain? Throbbing Stabbing Sharp Dull Cramping Burn Ache

What relieves your pain? Relaxation Medicine Nothing Heat Exercise distraction

Does your pain effect? Sleep Relationships Quality of Life Physical Activity Emotions Concentration

Nutrition

Have you had any unintentional weight change? No change Loss Gain

Any appetite changes? No change Increase Decrease

Difficulties preventing eating? No Vomiting Taste Swallowing Nausea Diarrhea/constipation

Current diet? Tube feeding Soft foods Regular Low sodium Low fat liquid diabetic cardiac

Do you take any vitamin supplements? No Yes

Do you drink any meal supplement shakes? No Yes

Do you have any cultural, ethnic or religious restrictions on your diet? No Yes

Who feeds you? Self Family Member Care giver

Functional Level

Ability to dress upper body? Independent Minimum help Moderate help Dependent

Ability to dress lower body? Independent Minimum help Moderate help Dependent

Bathing? Independent Minimum help Moderate help Dependent

Transferring? Independent Minimum help Moderate help Dependent

Walking? Independent Minimum help Moderate help Dependent

Toileting? Independent Minimum help Moderate help Dependent

Work History

Do you work? No Yes Retired

What type of work do/did you do? ____

Will treatment have an impact on your work? No Yes

Advance Directives

Do you have Advance Directives? No Yes

Would you like to share a copy with the clinic? No Yes On file at hospital

Do you have a Do Not Resuscitate order? No Yes

Abuse

Have you ever been emotionally or physically abused? No Yes

Allergies

Are you allergic to Latex? No Yes

Are you allergic to any foods? No Yes If yes, please list ______________________________

Are you allergic to any medications? No Yes If yes, please list ________________________

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Vaccinations/Immunizations

Which vaccinations/immunizations have you had?

Hepatitis A Vaccine No Yes If yes, when? ________________________________

Hepatitis B Vaccine No Yes If yes, when? ________________________________

Influenza Vaccine No Yes If yes, when? ________________________________

Pneumonia Vaccine No Yes If yes, when? ________________________________

Measles Mumps Rubella Vaccine No Yes If yes, when? _______________________

Tetanus Vaccine No Yes If yes, when? ________________________________

Chickenpox Vaccine No Yes If yes, when? ________________________________

Medications

Name	Dose	Frequency

Vitamins/Supplements

Name	Dose	Frequency

Hospitalizations

Illness	Year / Discharge date	Facility

Surgeries

Illness	Year

Constitutional

- Chills
- Pain
- Fever
- Night sweats
- Appetite loss
- Fatigue
- Weight loss
- Weight gain

Skin

- Itching
- Pigment changes
- Acne
- Dermatitis
- History of Ulcers
- Suspicious mole
- Dryness
- Rashes
- Keloids

Immunologic

- HIV
- Pyoderma
- Vasculitis
- Lupus
- AIDS
- Scleroderma
- Rheumatoid

Eyes

- Retinal detachment
- Blind
- Macular degeneration
- Glaucoma
- Cataracts
- Contacts
- Glasses

Ears, Nose, Mouth, Throat

- Ear Implants
- Meniere's
- Dentures
- Difficulty swallowing
- Hearing loss
- Sinus surgery

Respiratory

- Blood tinged sputum
- Apnea
- Snoring
- Pulmonary fibrosis
- Allergy
- Oxygen dependent
- Asthma
- Bronchitis
- COPD
- Cold symptoms
- Cough
- Emphysema
- Shortness of breath
- Tuberculosis
- Wheezing

Heart Cardiovascular

- Pacemaker
- Angina
- Arrhythmia
- Heart failure
- Hypertension
- Hypotension
- Heart attack
- Heart murmur
- Orthopnea
- SOB with exertion
- Palpitations
- Chest pain

Peripheral Cardiovascular

- DVT
- Leg swelling
- Vein surgery
- Claudication
- Rest pain

Gastrointestinal

- Anorexia
- Liver disease
- Incontinent bowel
- Cirrhosis
- Hepatitis
- Stomach ulcers
- Jaundice

Skeletal

- Charcot Foot
- Previous amputation
- Muscle wasting
- Joint stiffness
- Arthritis
- Joint swelling

Neurological

- Neuropathy
- Paraplegia
- Quadriplegia
- Spinal cord injury
- Stroke
- Seizure disorder
- Dizziness
- Migraines

Endocrine

- Diabetes
- Hyperthyroid
- Other thyroid disease
- Hypothyroid
- Addison's disease

Hematologic/Lymphatic

- Bruises easily
- Lymphedema
- Bleeding disorder
- Hypercoagulable

Psychiatric

- PTSD
- Short term memory loss
- Alzheimer's
- Anxiety
- Claustrophobia
- Bipolar
- Psychosis
- Depression