CHRISTIANA CARE

AINFO

Wound Care & Hyperbaric Medicine Center

PATIENT HISTORY

Instruction:
To be completed by patient on initial visit and reviewed by nurse.

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: (_____) _____

SOCIAL HISTORY

Do you smoke: ☐ No ☐ Yes, how many years: _____ How many packs per day: _____ If quit, when: _____

Do you drink alcohol: ☐ Occasional ☐ Moderate ☐ Heavy ☐ Weekends Only ☐ None ☐ Other: _____

Do you use recreational drugs: ☐ No ☐ Yes, amount: _____ Type: _____

WOUND HISTORY

Wound location: _____

When did you first notice the wound: _____

Has it ever healed and then re-opened: ☐ Yes ☐ No

How did your wound start (mark all that apply): ☐ Gradually appeared ☐ Not known ☐ Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Pimple ☐ Pressure ☐ Radiation burn ☐ Surgical ☐ Thermal burn ☐ Trauma ☐ Other lesion ☐ Other: _____

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 tested positive for an antibiotic resistant organism (MRSA, VRE): ☐ No ☐ Yes, date: ____ /_____ /_____

Have you tested positive for osteomyelitis (bone infection): ☐ No ☐ Yes, date: ____ /_____ /_____

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: ☐ Infection ☐ Swelling ☐ Other: _____

_____

PATIENT'S MEDICAL HISTORY (mark Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)	☐	☐	Cirrhosis (Liver problems)	☐	☐
Glaucoma (Eye disease)	☐	☐	Colitis/Crohn's (Bowel problems)	☐	☐
Chronic Sinus problems/congestion	☐	☐	Hepatitis (Type: _____)	☐	☐
Middle ear problems	☐	☐	Thyroid Disease	☐	☐
Ear Surgery	☐	☐	Diabetes (Type: _____)	☐	☐
Anemia (Tired, or low iron)	☐	☐	End Stage Renal Disease (Kidney disease)	☐	☐
Hemophilia (Bleeding disorder)	☐	☐	On Dialysis (Type: _____)	☐	☐
Human Immunodeficiency Virus (HIV)	☐	☐	Lupus (Problem with your immune system)	☐	☐
Lymphedema (Swelling in legs or arms)	☐	☐	Raynaud's Syndrome	☐	☐
Sickle Cell Disease	☐	☐	Scleroderma (Skin disorder)	☐	☐
Aspiration	☐	☐	Rheumatoid Arthritis (Swelling of joints)	☐	☐
Asthma (Breathing problem)	☐	☐	History of Burn	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)	☐	☐	Gout (Pain in big toes)	☐	☐
Pneumothorax (Collapsed lung)	☐	☐	Osteoarthritis (Pain in bones or joints)	☐	☐

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PATIENT HISTORY

PATIENT'S MEDICAL HISTORY (continued)					
	Yes	No		Yes	No
Sleep Apnea (Stop breathing when sleeping)	☐	☐	Dementia (Memory loss that gets worse over time)	☐	☐
Tuberculosis (Infection in the lungs)	☐	☐	Neuropathy (Numbness in hands or feet)	☐	☐
Angina (Chest pain)	☐	☐	Paraplegia (Can't move arms or legs)	☐	☐
Arrhythmia (Skipped heartbeat)	☐	☐	Quadriplegia (Can't move arms and legs)	☐	☐
Atrial Fibrillation (Rapid heart rate)	☐	☐	Received Chemotherapy	☐	☐
Congestive Heart Failure (CHF)	☐	☐	Surgery	☐	☐
Coronary Artery Disease (CAD) (Heart disease)	☐	☐	Anorexia/bulimia	☐	☐
Deep Vein Thrombosis (DVT) (Blood clot in leg)	☐	☐	Phlebitis (Inflammation of the veins in your legs)	☐	☐
Hypertension (High blood pressure)	☐	☐	Infection (Bacteria resistant to antibiotics)	☐	☐
Hypotension (Low blood pressure)	☐	☐	Bone infection (location: _____)	☐	☐
Myocardial Infarction (MI) (Heart attack)	☐	☐	Peripheral Venous Disease (PVD) (Problem with blood vessels in your legs)	☐	☐
Peripheral Arterial Disease (PAD) (Problem with blood flow in your legs)	☐	☐			
Vasculitis (Inflammation of your blood vessels)	☐	☐			

FAMILY MEDICAL HISTORY (Please mark if any of your family members have/had this condition)					
Condition	**Maternal Grandparents**	**Paternal Grandparents**	**Mother**	**Father**	**Siblings**
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other (list):_____	☐	☐	☐	☐	☐

HOSPITALIZATION/SURGERY HISTORY		
NAME OF HOSPITAL	**REASON YOU WERE IN THE HOSPITAL**	**DATE**
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

Person Completing Form:

_____ _____ ___/___/___ _____

Signature of Patient or Representative | Relationship to Patient | Date | Time

FOR NURSE USE ONLY

NOTES:

☐ Patient history reviewed, no clarification needed

☐ Patient history reviewed, clarification as follows:

_____ _____ ___/___/___ _____

Nurse Signature/Title | Print Name | Date | Time