Center for Advanced Wound Healing
Community Hospital Anderson

PATIENT NAME: _____

NEW PATIENT MEDICAL HISTORY

CHIEF COMPLAINT: (WHAT IS THE REASON FOR YOUR VISIT TODAY?)

_____

_____

HISTORY OF PRESENT ILLNESS:

LOCATION: (WHERE IS YOUR WOUND LOCATED?)

_____

DURATION: (HOW LONG HAVE YOU HAD THE WOUND?)

_____

CONTEXT: (HOW DID YOUR WOUND OCCUR OR DEVELOP?)

_____

ASSOCIATED SIGNS/SYMPTOMS: DESCRIBE ANY SIGNS OR SYMPTOMS OF YOUR WOUND (SUCH AS, DRAINAGE, ODOR, NUMBNESS, ETC.)

_____

_____

_____

_____

TIMING: (DO YOU HAVE PAIN IN OR AROUND THE WOUND?) ☐ No ☐ Yes

IF YES, IS THE PAIN ☐ CONSTANT *(HURTS ALL THE TIME)* OR ☐ INTERMITTENT *(COMES AND GOES)?*

QUALITY: (DESCRIBE YOUR PAIN BY CHECKING ALL THAT APPLY BELOW)

☐ ACHING ☐ BURNING ☐ THROBBING ☐ STABBING ☐ SHOOTING ☐ SHARP ☐ DULL ☐ HEAVY

☐ CRAMPING ☐ EXHAUSTING ☐ SPLITTING ☐ TENDER ☐ EASY TO PINPOINT ☐ DIFFICULT TO PINPOINT

MODIFYING FACTORS: (DESCRIBE OR LIST ANY CONDITIONS OR ACTIVITIES THAT IMPACT YOUR WOUND, SUCH AS PAIN WHEN WALKING OR RAISING YOUR LEG)

_____

_____

_____

** HAS YOUR WOUND EVER HEALED AND THEN RE-OPENED? ☐ No ☐ Yes

** HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH? ☐ No ☐ Yes; IF YES, WHERE:_____

** HAVE YOU HAD ANY TESTS FOR CIRCULATION IN YOUR LEGS? ☐ No ☐ Yes; IF YES, WHERE:_____

** WHO ORDERED ABOVE TESTS? LAB_____ CIRCULATION:_____

** HOW HAVE YOU BEEN TAKING CARE OF YOUR WOUND?

_____

_____

** *INFORMATION IS NOT COLLECTED IN THE CLINICAL DATABASE*

PATIENT NAME: _____

ALLERGIES: *(LIST ALL KNOWN ALLERGIES AND REACTIONS)*

☐ NO KNOWN ALLERGIES ☐ LATEX / RUBBER ☐ TAPE ☐ IODINE

☐ FOOD (LIST): _____

☐ MEDICATIONS (LIST): _____

☐ OTHER: (LIST):

ADVANCED DIRECTIVES & INSTRUCTIONS: *(CHECK ALL THAT APPLY)*

☐ I HAVE AN ADVANCE DIRECTIVE ☐ I HAVE A LIVING WILL

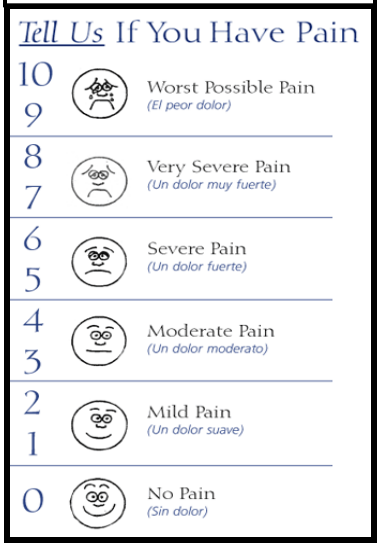
☐ ADVANCE DIRECTIVE MATERIALS WERE PROVIDED TO ME

☐ I HAVE A COPY OF MY LIVING WILL FOR THE HOSPITAL

☐ I HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE

☐ I DO NOT WANT TO BE RESUSCITATED

SEVERITY: CIRCLE THE NUMBERS THAT BEST DESCRIBE YOUR CURRENT LEVEL OF PAIN



REVIEW OF SYSTEMS / PAST MEDICAL & SURGICAL HISTORY

CONSTITUTIONAL (GENERAL HEALTH)

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Active			
Fatigue *(tired all of the time)*			
Fever			
Loss of Appetite			
Marked Weight Change			
Sedentary *(low activity level)*			
Night Sweats			

MEDICAL HISTORY	YES	NO	COMMENTS
Influenza *(Flu)* Vaccine Current			
Pneumonia Vaccine Current			
Tetanus Vaccine Current			
Sleep Apnea			

ALLERGIC / IMMUNOLOGIC

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Rhinitis *(inflamed nasal passage)*			
Hay Fever			

MEDICAL HISTORY	YES	NO	COMMENTS
AIDS / HIV			
Lupus			
Pyoderma Gangrenosum			
Reynaud's Disease			
Rheumatoid Arthritis			

CARDIOVASCULAR (CENTRAL / PERIPHERAL)

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Dyspnea on exertion *(shortness of breath with activity)*			
Edema *(swelling)*			
Intermittent Claudication *(pain on exertion, i.e. walking to mailbox)*			

Orthopnea *(shortness of breath when lying down)*			
Palpitations			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Congestive Heart Failure			
Coronary Artery Disease *(CAD)*			
Deep Vein Thrombosis *(clot in the vein)*			
Hyperlipidemia *(High cholesterol)*			
Hypertension *(High blood pressure)*			
Murmur			
Myocardial Infarction *(Heart attack)*			
Peripheral Vascular Disease			
Rheumatic Fever			
Vasculitis			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Coronary Artery Bypass Surgery			
Greenfield Filter			
Left Ventricular Assist Device			
Pacemaker/Defibrillator			
Peripheral Bypass surgery			
Stent Placement			
Subfascial endoscopic perforator surgery *(SEPS)*			
Valve Replacement			
Vein Stripping			
EAR / NOSE / MOUTH / THROAT			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Hearing Loss / Aid			
Otalgia *(ear ache)*			
Dental Problems			
Painful or Swollen Lymph Nodes			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Barotrauma *(damage to ear drum)*			
Sinusitis			
Tinnitus *(ringing in ears)*			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Myringotomy *(incision in eardrum)*			
Tube Placement *(in ear)*			
EYES			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Blurred Vision			
Dry Eyes			
Vision Changes			
Glasses / Contacts			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cataracts			
Glaucoma			
Retinopathy *(damage to the retina)*			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Other			
ENDOCRINE			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Cold Intolerance			

Heat Intolerance			
Polydypsia *(Excessive thirst)*			
Polyuria *(Excessive urination)*			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Gestational Diabetes *(with pregnancy)*			
Thyroid Disease			
Type 1 Diabetes *(juvenile onset)*			
Type 2 Diabetes *(adult onset)*			
GASTROINTESTINAL (GI)			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Bowel Incontinence			
Change in Bowel Habits			
Jaundice			
Nausea / Vomiting / Diarrhea			
Loss of Appetite			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cirrhosis of the Liver			
Crohn's Disease			
Gastro Esophageal Reflux *(GERD)*			
Hepatitis *(liver infection)*			
Special Diet			
Ulcerative Colitis			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Colectomy *(remove part large colon)*			
Colostomy			
Ileostomy			
GENITOURINARY (GU)			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Frequency			
Urinary Incontinence			
Pregnant			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Benign Prostate Hyperplasia *(enlarged prostate)*			
Dialysis			
End Stage Renal Disease			
Kidney Disease			
Miscarriage			
Prostate Cancer			
Sexually Transmitted Disease			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Previous OB/GYN Surgery			
HEMATOLOGIC / LYMPHATIC			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Bruising			
Bleeding / Clotting Disorders			
Blood Transfusion			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Anemia *(low blood count)*			
Anticoagulant Therapy			
Lymphedema			
Sickle Cell Anemia			
INTEGUMENTARY (HAIR / SKIN / NAILS)			

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Pruritis *(Itching)*			
Rash			
Skin Allergies			
Calluses/Corns			
Prone to Skin Tears			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Malignancy *(skin cancer)*			
Onchomycosis *(nail fungal infection)*			
Scleroderma			
MUSCULOSKELETAL			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Backache			
Contractures			
Deformities			
Muscle Pain			
Muscle Wasting			
Muscle Weakness			
Assistive Devices			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Arthritis			
Gout			
Hip Fracture			
Osteoarthritis			
Osteomyelitis *(bone infection)*			
Osteoporosis			
Other Fracture			
SURGICAL HISTORY	**YES**	**NO**	**COMMENTS**
Achilles Tendon Lengthening			
Amputation			
Back Surgery			
Foot Surgery			
Implanted Surgical Hardware			
Joint Replacement			
NEUROLOGICAL			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Abnormal Gait			
Dizziness			
Loss of Protective Sensation			
Numbness			
Tingling			
Tremors			
Vertigo *(dizziness)*			
Weakness			
Headaches			
Paralysis			
Seizures			
Syncope *(brief fainting episode)*			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Amyotrophic Lateral Sclerosis *(ALS)*			
CNS Trauma Injury			
Epilepsy			
Head Injury / LOC			
Multiple Sclerosis			

Stroke			
Transient Ischemic Attack *(TIA / mini-stroke)*			
PSYCHIATRIC			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Anxiety			
Claustrophobia			
Insomnia			
Nervousness / Tension			
Memory Loss			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Alzheimer's			
Dementia *(loss of mental skills)*			
Depression			
RESPIRATORY			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Cough			
Hemoptysis *(coughing blood)*			
Shortness of Breath			
Wheezing			
Oxygen in Use			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Abnormal Chest X-ray			
Asthma			
Chronic Obstructive Pulmonary Disease *(COPD)*			
Emphysema			
Pneumonia			
Pneumothorax *(collapsed lung)*			
Positive TB Test			
Pulmonary Embolus *(blood clot in lung)*			
Tuberculosis			
Upper Respiratory Infection *(URI)*			
ONCOLOGIC			
COMPLAINTS & SYMPTOMS	**YES**	**NO**	**COMMENTS**
Cancer			Type:
Receiving Chemotherapy			
Receiving Radiation			
MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Cancer			Type:
Received Chemotherapy			
Received Radiation			
Type of Cancer			
FAMILY & SOCIAL HISTORY			
FAMILY HISTORY	**YES**	**NO**	**COMMENTS**
Cancer			
Diabetes			Type I: _____ Type II: ____ Date Onset: _____
Heart Disease			
Hypertension			
Kidney Disease			
Lung Disease			
Mental Illness			
Seizures			
Stroke			
Thyroid Problems			
Tuberculosis			

Social History	
Substance Abuse	☐ No ☐ Yes | Describe:
Alcohol Use:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use:	☐ Never ☐ Former ☐ Less than 1 Pack Per Day ☐ Greater than 1 Pack Per Day | Years:
Smokeless Tobacco Use:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Caffeine Use:	☐ Never ☐ Previously ☐ Currently | Type / Frequency:
Illicit Drug Use:	☐ Never ☐ Previously ☐ Currently | Type / Frequency:
Occupation:	
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:
Children	☐ No ☐ Yes | If Yes, how many:
Cultural, Religious or Language Concerns:	
Support Systems Lacking:	
Transportation Concerns (able to drive, etc.)?:	
Able to Care for Self (dressing, bathing, etc.)?	☐ No ☐ Yes If "No", explain :

MEDICATIONS - - Write on Back if more room needed

[Please list all medicines you are currently taking - - Include over the counter, herbal & vitamin supplements]

Medications	**Amount / Dosage**	**How Often**

NUTRITION ASSESSMENT / SCREEN

History	**Yes**	**No**	**Action Plan**
Difficulty Chewing or Swallowing **[1]**			
Do You Need Assistance with Eating **[1]**			
Have You Had a Weight Loss or Gain > 10 lbs in Past 6 Months **[2]**			
If Yes, _____ lbs in _____ months			Reason, if known:
Intentional Weight Loss from Program or Medications **[1]**			
Do You Follow a Special Diet **[1]**			
Do You Have Any Food Allergies **[1]**			
Do You Have a **Good** Appetite **[0]**			
Do You Have a **Fair** Appetite **[1]**			
Do You Have a **Poor** Appetite **[2]**			
Do You Take Nutritional Supplements **[0]**			
Do You Drink Several 8 oz Glasses of Water Each Day **[0]**			
RISK LEVEL: **Low** = less than or equal to 2 | **High** = greater than 3 (Staff Use Only)			**SCORE:**

General Notes

Patient Signature: _____ **DATE:** _____ **TIME:** _____
(Or Legal Guardian/POA)

I have reviewed the New Patient Medical History with the patient / caregiver as part of the Initial Nursing Assessment.

Nurse Signature: _____ **DATE:** _____ **TIME:** _____