

## PATIENT HISTORY

### GENERAL INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

NO P.O. BOX PLEASE

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Level of Education \_\_\_\_\_

### **Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### **What physician referred you to the center?**

### **Who is your primary physician?**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Specialty \_\_\_\_\_ Phone \_\_\_\_\_

Specialty \_\_\_\_\_ Phone \_\_\_\_\_

**Are you currently with a Home Health Care Agency or Nursing Home?** \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ Phone \_\_\_\_\_

**Have you ever been a patient at Heart of Florida Regional Medical Center?**       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: \_\_\_\_\_



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**MEDICAL HISTORY** Please check Yes or No for each item

	PATIENT		MANAGING PHYSICIAN	FAMILY		EXPLAIN (Who, Age)
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If you have diabetes:</b> Do you take: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled How long have you had diabetes? _____ Do you test your blood sugar every day? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many times /day _____
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis/Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE



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**SYSTEM REVIEW Please check Yes or No for each item**

**GENERAL SYMPTOMS**

Good general health lately  Yes  No  
 Fatigue  Yes  No

**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

**ENDOCRINE/HEPATIC**

Thyroid disease  Yes  No  
 Excessive thirst/urination  Yes  No  
 Heat/cold intolerance  Yes  No  
 Hepatitis  Yes  No

**CARDIOVASCULAR**

Pain in legs  Yes  No  
 Blood Clots  Yes  No  
 Poor Circulation  Yes  No  
 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

**MENTAL HEALTH**

Depression  Yes  No  
 Anxiety  Yes  No  
 Bipolar  Yes  No  
 Schizophrenia  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

If yes where do you receive dialysis:

What days do you receive dialysis:

Kidney transplant  Yes  No

**OTHER CONCERNS**  Yes  No

If yes, explain:



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PATIENT HISTORY CONTINUED

**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 \_\_\_\_\_

**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 if yes, date Received \_\_\_\_\_

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** \_\_\_\_\_



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