JUPITER MEDICAL CENTER

WOUND CARE CENTER PATIENT HISTORY

GENERAL INFORMATION		DATE:	
Name		Primary Phone	
Address		Secondary Phone	
City		State	Zip
E-mail	Date of Birth	Age	Sex

SOCIAL HISTORY

Do you live alone: ☐ Yes ☐ No	Do you drive: ☐ Yes ☐ No	Employed: ☐ Yes ☐ No
What is the highest school grade you completed? ☐ 1-6 ☐ 7-9 ☐ 10 ☐ 11 ☐ 12 ☐ Some college ☐ College graduate		
Marital Status: ☐Separated ☐Divorced ☐Married ☐Single ☐ Widowed		Spouse Name:
Do you smoke: ☐ Yes ☐ No If Yes, for how many years: How many packs per day:		If quit, when:
Do you drink alcohol: ☐ No History ☐ Prior History ☐ Current History	Type:	
Do you use recreational drugs: ☐ Yes ☐ No If Yes, amount:		Type:
Caffeine Use: ☐ Yes ☐ No If Yes, for how many years:		How many cups per day:
Financial Concerns: ☐ Yes ☐ No		Food/Clothing/Shelter Needs: ☐ Yes ☐ No
Support System Intact: ☐ Yes ☐ No		Transportation Concerns: ☐ Yes ☐ No
How will you travel to center? ☐Car ☐Ambulance ☐Ambulette Public ☐Other		

EMERGENCY CONTACT INFORMATION

Name	Primary Phone
Relationship	Secondary Phone

What provider referred you to the Wound Care Center®?

Name	Specialty	Phone	
Address	City	State	Zip

Who is your primary provider?

Name	Specialty	Phone	
Address	City	State	Zip

If your provider did not refer you, how did you hear about our Wound Care Center®?

☐Self-Referral	☐Extended Care Facility (SNF, LTAC, Nursing Home)	☐Advertising
☐Former Patient	☐Recently discharged from hospital	☐Home Health

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

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Do you have any of the following?

Advance Directive: ☐ Yes* ☐ No	Living Will: ☐ Yes* ☐ No	Medical Power of Attorney: ☐ Yes* ☐ No	Do Not Resuscitate: ☐ Yes* ☐ No

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? ☐Bite ☐Blister ☐Bruise ☐Bump ☐Chemical Peel ☐Footwear ☐Frostbite ☐Gradually Appeared ☐Not Known ☐Other Lesion ☐Pimple ☐Pressure ☐Radiation ☐Burn ☐Surgical ☐Thermal Burn ☐Trauma	
How have you been treating your wound until now?	
Have you had any lab work done in the past month? ☐ Yes ☐No If Yes, Who Ordered?	
Have you ever had a bacteria that resisted antibiotics? ☐Yes ☐No	If Yes, Date:
Have you ever had a bone infection? ☐Yes ☐No	If Yes, Date:
Have you had any tests for blood flow in your legs? ☐Yes ☐No	If Yes, Date:
If Yes, Where was it done: Who Ordered?	
Have you had any other problems with your wound? ☐Infection ☐Swelling ☐Other	

PATIENT'S MEDICAL HISTORY (Please check 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			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type:_____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow toyour fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		

WOUND CARE CENTER PATIENT HISTORY

	Yes	No		Yes	No
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)			Surgery		
Deep Vein Thrombosis (Blood clot in leg)			Anorexia/bulimia		
Hypertension (High blood pressure)			Confinement Anxiety (Fear about being in a closedspace)		
Hypotension (Low blood pressure)			Peripheral Venous Disease (Problem with bloodvessels in your legs)		
Myocardial Infarction (Heart attack)			Phlebitis (Inflammation of the veins in your legs)		
Peripheral Arterial Disease (Problem with bloodflow in your legs)					
Vasculitis (Inflammation of your blood vessels)					

FAMILY MEDICAL HISTORY

(Please indicate with a checkmark 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					
Tuberculosis					

WOUND CARE CENTER PATIENT HISTORY

HOSPITALIZATION/SURGERY HISTORY (Please list all)

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE
Please provide a list of your current medications or bring your current medications, including over the countermedications, herbal supplements and vitamins to the Wound Care Center® for your first visit.		

For Healthcare Provider Use Only

NOTES:

*Copy required for chart. □ Copy provided
Requested by:_____ Date:_____Time: _____AM/PM
Signature:_____ Date:_____Time: _____AM/PM

Name of Person Completing Form:_____

Relationship to Patient: _____

Signature:_____Date:_____Time: _____AM/PM

Reviewed By:_____ Date:_____Time: _____AM/PM