O'CONNOR HOSPITAL
A COMMUNITY HOSPITAL

PATIENT LABEL

Center for Advanced Wound Care New Patient Questionnaire

These questions are general screening questions designed to identify areas where additional attention may be required. Please bring this form to your appointment. Thank you.

Patient Name: _____ **Weight:** _____ **Height:** _____

Date of Birth: _____ **Primary Care Physician, phone #:** _____

Pharmacy (name, phone #, address): _____

Home Health (Agency and phone #): _____

Which physician sent you to the wound care clinic? _____

What specialties are you seeing for your medical care (cardiologist, endocrinologist, nephrologist, etc.)

_____

_____

Name and Address of Resident or Facility. Example: nursing home, residential care home:

_____

Name of caregiver (if applicable): _____ Relationship: _____

Phone number of caregiver: _____

Reason for today's visit (chief complaint):

_____

_____

When did you become aware of this problem: _____

Where is your wound/injury located: _____

Do you have someone to help you with wound care at home? ☐ Yes ☐ No

If yes, who? _____ Phone number: _____

How did you get here: ☐ Car ☐ Ambulance ☐ Outreach

Ambulance phone number: _____ Outreach phone number: _____

Do you have any allergies (please list)?

Food	No / Yes
Penicillin	No / Yes
Sulfa	No / Yes
Iodine	No / Yes
Aspirin	No / Yes
Novocaine	No / Yes
Codeine	No / Yes
Adhesive Tape	No / Yes
Latex	No / Yes

Other: _____

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Medications:
Please list all medications you take. Please include name, dosage, and how often you take the medication.

Medication	Purpose	Dosage/Amount	How often

Are you taking any blood thinning medication: ☐ Yes ☐ No

Surgeries: List previous hospitalizations, major surgeries, serious injuries, and approximate dates:

Past Medical History: Check YES or NO for any significant conditions that apply

	Y	N	Date of Onset		Y	N	Date of Onset
Anemia	☐	☐		Hay Fever/Sinus Problems	☐	☐	
Asthma/Bronchitis/Emphysema	☐	☐		Heart Problems	☐	☐	
Arthritis	☐	☐		Hepatitis	☐	☐	
Bleeding/Bruising/Blood Disorder	☐	☐		High Blood Pressure	☐	☐	
Cancer (type)	☐	☐		Immune Disorder	☐	☐	
Depression	☐	☐		Kidney Disorder	☐	☐	
Diabetes	☐	☐		Liver Disease	☐	☐	
Insulin Injection Dependent	☐	☐		Stroke	☐	☐	
Non-Insulin Dependent	☐	☐		Thyroid Disease	☐	☐	
Drug Abuse/Alcohol Dependency	☐	☐		Tuberculosis (TB)	☐	☐	
Epilepsy/Seizures	☐	☐		Stomach Ulcers	☐	☐	

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Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Have you noticed any lumps or bumps? State location: _____

Other (describe): _____

Have you had previous treatment with or exposure to radiation: ☐ Yes ☐ No

Family History:

List health problems in your family:

	Age	Medical Problems	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
Grandparents	_____	_____	_____

Social History:

Tobacco use: ☐ Yes ☐ No

Cigarettes: Pack(s) per day: _____ How many years: _____ If you quit, when? _____

Other tobacco use: Amount per day: _____ How many years: _____ If you quit, when? _____

Alcohol use: ☐ Yes ☐ No If yes, how much? _____

Do you use any drugs other than prescribed or over the counter medication? ☐ Yes ☐ No

If yes, please list: _____

Do you eat a balanced diet? ☐ Yes ☐ No Is your weight stable? ☐ Yes ☐ No

Indicate any other important information the doctor should know:

_____

_____

_____

_____

Marital status/Relationship: _____

Who currently lives at home with you? _____

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Review of Systems:
Do you presently have any problems or symptoms in the following areas? If yes, give an explanation.

Constitutional:	Yes	No
Good health		
Recent weight changes		
Recurrent fever, chills, sweats		
Fatigue		
Eyes:		
Wear glasses/contacts		
Blurred or double vision		
Change in vision		
Glaucoma		
Ear/Nose/Mouth/Throat:		
Change in hearing		
Ringing in ears		
Recent nose bleeds		
Chronic sinus problems		
Mouth sores		
Frequent sore throats		
Voice changes		
Respiratory:		
Asthma or wheezing		
Breathing problems		
Coughing up blood		
Chronic cough		
Pneumonia		
Cardiovascular:		
Heart trouble or heart attack		
Chest pain or angina		
Shortness of breath		
Palpitations		
Swelling of feet, ankle, or hands		
Blood clots		
Varicose veins		

Gastrointestinal:	Yes	No
Change in appetite		
Severe heartburn		
Bleeding ulcers		
Frequent nausea/vomiting		
Vomiting blood		
Frequent diarrhea		
Constipation		
Painful bowel movements		
Black or bloody stool		
Rectal bleeding		
Abdominal pain		
Genitourinary:		
Blood in urine		
Burning with urination		
Change in force of stream when urinating		
Sexually transmitted disease		
Change in sexual function or interest		
Men:		
Prostate trouble		
Scrotal masses		
Women:		
Pain/problems with period		
Abnormal uterine bleeding		
Uterine tumors		
Neurological:		
Headaches		
Numbness or tingling sensations		
Weakness or paralysis		
Convulsions or seizures		
Change in memory or concentration		

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Integumentary (skin and breasts):	Yes	No
Birth marks		
Recent rashes		
Changing moles		
Skin cancer or melanoma		
Non-healing wounds		
Change in hair or nails		
Breast pain or lump		
Psychiatric:		
Memory loss or confusion		
Nervousness		
Depression		
Change in sleep		
Musculoskeletal:		
Joint stiffness or pain		
Muscle pain or cramping		
Weakness of muscles or joints		
Difficulty walking		
Back pain		

Endocrine:	Yes	No
Heat or cold intolerance		
Excess thirst or urination		
Thyroid problems		
Allergic/Immunologic:		
Low resistance to infection		
Recent cold or flu		
Environmental allergies		
Reactions to medication(s)		
Tetanus booster within the past 10 years		
Other immunizations up to date		
Hematologic/Lymphatic:		
Easy bruising		
Frequent bleeding		
Enlarged lymph nodes		

Please explain all "Yes" as indicated above:

Signature of person completing form

Relationship (if other than patient)

Print Name

Date

Time

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PROVIDER DOCUMENTATION

Instructions to Attending Physician:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

_____
Attending Physician Signature/Title

_____ _____ _____
Print Name Date Time

The preceding information was also reviewed by:

_____
Clinician Signature

_____ _____ _____
Print Name Date Time

Translated by _____ Translator # _____ Date _____
☐ Translation not required

This information was scribed into the medical record by:

_____

Disposition: scanned to efile date _____ initials _____