

Center for Advanced Wound Care New Patient Questionnaire Page 1 of 6

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hay Fever/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Bruising/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insulin Injection Dependent	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Abuse/Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____

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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	Gastrointestinal:	Yes	No
Good health			Change in appetite		
Recent weight changes			Severe heartburn		
Recurrent fever, chills, sweats			Bleeding ulcers		
Fatigue			Frequent nausea/vomiting		
			Vomiting blood		
Eyes:			Frequent diarrhea		
Wear glasses/contacts			Constipation		
Blurred or double vision			Painful bowel movements		
Change in vision			Black or bloody stool		
Glaucoma			Rectal bleeding		
			Abdominal pain		
Ear/Nose/Mouth/Throat:					
Change in hearing			Genitourinary:		
Ringing in ears			Blood in urine		
Recent nose bleeds			Burning with urination		
Chronic sinus problems			Change in force of stream when urinating		
Mouth sores			Sexually transmitted disease		
Frequent sore throats			Change in sexual function or interest		
Voice changes			Men:		
			Prostate trouble		
Respiratory:			Scrotal masses		
Asthma or wheezing			Women:		
Breathing problems			Pain/problems with period		
Coughing up blood			Abnormal uterine bleeding		
Chronic cough			Uterine tumors		
Pneumonia					
			Neurological:		
Cardiovascular:			Headaches		
Heart trouble or heart attack			Numbness or tingling sensations		
Chest pain or angina			Weakness or paralysis		
Shortness of breath			Convulsions or seizures		
Palpitations			Change in memory or concentration		
Swelling of feet, ankle, or hands					
Blood clots					
Varicose veins					

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Integumentary (skin and breasts):	Yes	No	Endocrine:	Yes	No
Birth marks			Heat or cold intolerance		
Recent rashes			Excess thirst or urination		
Changing moles			Thyroid problems		
Skin cancer or melanoma					
Non-healing wounds			Allergic/Immunologic:		
Change in hair or nails			Low resistance to infection		
Breast pain or lump			Recent cold or flu		
			Environmental allergies		
Psychiatric:			Reactions to medication(s)		
Memory loss or confusion			Tetanus booster within the past 10 years		
Nervousness			Other immunizations up to date		
Depression					
Change in sleep			Hematologic/Lymphatic:		
			Easy bruising		
Musculoskeletal:			Frequent bleeding		
Joint stiffness or pain			Enlarged lymph nodes		
Muscle pain or cramping					
Weakness of muscles or joints					
Difficulty walking					
Back pain					

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:
