Patient's Medical History *(Please check Yes or No for each item.)*

Cardiovascular	Yes	No
Angina		
Congestive Heart Failure		
Coronary Artery Disease		
Deep Vein Thrombosis		
Hypertension		
Hypotension		
Myocardial Infarction		
Peripheral Arterial Disease		
Peripheral Venous Disease		
Stroke		
Vasculitus		

Gastrointestinal	Yes	No
Cirrhosis		
Colitis		
Crohn's Disease		
Hepatitis (Type: _____)		

Neurological	Yes	No
Dementia		
Epilepsy		
History of Seizures		
Neuropathy		
Paraplegia		
Quadriplegia		

Pulmonary	Yes	No
Emphysema		
Pulmonary Embolism		
Asthma		
Chronic Obstructive Pulmonary Disease		
Collapsed Lung/Pneumothorax		
Use Supplemental Oxygen		

Musculoskeletal	Yes	No
Gout		
Osteoarthritis		
Rheumatoid Arthritis		

Ear / Nose / Mouth / Throat	Yes	No
Chronic Sinus problems/congestion		
Middle ear problems		

Immunizations: *When was your last tetanus shot?*

Endocrine	Yes	No
Hyperthyroid		
Hypothyroid		
Diabetes		

If Yes*, for how long:

Do you take: ☐ Insulin ☐ Oral Agents ☐ Diet Controlled

Do you test your blood sugar every day?

☐ Yes How Often:_____ ☐ No

What are your usual blood sugar results:

Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime: _____

Eyes	Yes	No
Cataracts		
Diabetic Retinopathy		
Glaucoma		

Genitourinary	Yes	No
Dialysis		
End Stage Renal Disease		

Hematologic/Lymphatic	Yes	No
Anemia		
Leukocytopenia		
Lymphedema		
Sickle Cell Disease		
Thrombocytopenia		

Immunological	Yes	No
Lupus		
Raynaud's Syndrome		
Scleroderma		

Integumentary	Yes	No
History of Burn		

Oncological	Yes	No
History of Chemotherapy		
Type:		
History of Radiation		

Psychiatric	Yes	No
Confinement Anxiety		
Depression		

Reproductive	Yes	No
Miscarriage		

Any implantable devices?

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					
Hereditary Spherocytosis					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Thyroid					
Tuberculosis					

Hospitalization/Surgery History *(Please list all past hospitalizations.)*

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

Notes: _____

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center for your first visit.

Person Completing Form: _____ **Relationship to Patient:** _____ **Date:** _____ **Time:** _____
Signature

Reviewed By: _____ _____
RN Signature Date Time Physician Signature Date Time

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Lake Charles Memorial
WOUND CARE

(Patient Label / Addressograph)

Patient History

Date: _____

General Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Do you live alone: ☐ No ☐ Yes Do you drive: ☐ No ☐ Yes

Emergency Contact Information

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

What physician suggested you visit this Center?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Who is your primary physician?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Health Care/Nursing Home: _____ Phone: _____

Pharmacy: _____ Phone: _____

Do you have any of the following?

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

*Copy Required to be in Chart: Initials: _____ Date: _____ Time: _____

☐ Copy Provided: Initials: _____ Date: _____ Time: _____

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 (wounding event)? ☐ Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Gradually Appeared ☐ Not Known ☐ Other Lesion ☐ Pimple ☐ Pressure ☐ Radiation Burn ☐ Surgical ☐ Thermal Burn ☐ Trauma ☐ Other: _____

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 tested positive for an antibiotic resistant organism (MRSA, VRE)? ☐ No ☐ Yes, Date: _____

Have you tested positive for osteomyelitis (bone infection)? ☐ No ☐ Yes, Date: _____

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: _____

Person Completing Form: _____ **Relationship to Patient:** _____ **Date:** _____ **Time:** _____
Signature

Reviewed By: _____ _____ _____ _____
RN Signature Date Time Physician Signature Date Time

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