WELCOME NEW PATIENTS

WASHINGTON HEALTH SYSTEM
Wound and Skin Healing Center

Date _____
Name_____DOB _____
Address _____ City _____ State _____ Zip _____

Emergency Contact:_____ Phone_____ Relationship _____

Are you currently a patient of an alternate wound center? ☐ Yes ☐ No
If Yes, which one? _____
Who referred you to our practice?
☐ Physician - Name _____ ☐ Friend ☐ Other _____
Who is your Primary Care Physician? _____
Name _____ Address _____ Phone_____

Do you have Home Health Care? ☐ Yes ☐ No
If Yes, name of Home Health Agency _____ Phone_____

Do you have transportation assistance? ☐ Yes ☐ No
If Yes, name of transportation agency _____ Phone_____

Wound History

Wound location _____
When did you first notice the wound? _____
How did the wound start? _____

Has the wound ever healed and then reopened? ☐ Yes ☐ No

Does your wound prevent you from performing daily activities? ☐ Yes ☐ No

How have you been treating your wound until now? ☐ Physician ☐ Wound Center

Have you had X rays done in the past 30 days? ☐ Yes ☐ No
If Yes, where? _____ Date of X ray _____

Have you had any lab work done in the last 30 days? ☐ Yes ☐ No
If Yes, where? _____ Date of bloodwork _____

Past Medical History: Circle all that apply

Atrial Fibrillation
Cancer
Cardiomyopathy
Convulsions / Seizures
COPD (Lung Disease)
Coronary Artery Disease (Heart Disease)
Crohn's Disease
CVA (Stroke)
Dementia
Depression
Diabetes (Insulin Dependent)
Diabetes (Non Insulin Dependent)
Emphysema / Black Lung
Gout
Hypertension (High Blood Pressure)
Kidney Disease
Lupus
Paralysis
Phlebitis (Blood Clots)
Rheumatoid Arthritis
Scleroderma
Ulcerative Colitis
Other: _____
Other: _____

If you are a diabetic, please answer the following questions:

Do you take ☐ Insulin ☐ Oral agents ☐ Diet controlled

How long have you known you have had diabetes? _____

Do you test your blood sugar every day? ☐ Yes ☐ No

If Yes, how many times /day? _____

Do you know your Hemoglobin A1C level? ☐ Yes ☐ No

If Yes, what is the level? _____

What are your blood sugar testing results?

Breakfast _____ Lunch _____

Dinner _____ Bedtime _____

Please list all medications you are currently taking:

MEDICATION	AMOUNT (DOSE)	FREQUENCY

ALLERGIES: Please list all known drug, food and environmental allergies

_____

_____

HOSPITALIZATION / SURGICAL HISTORY: Please provide brief description

REASON FOR HOSPITALIZATION / SURGERY	DATE

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Yes ☐ No If Yes, Type _____ Amount _____

Alcohol Use: ☐ Yes ☐ No ☐ Rarely ☐ Moderate ☐ Daily

Recreational Drug Use: ☐ Yes ☐ No If Yes, Type / Frequency _____

Nutrition Profile

Have you experienced large weight loss or gain? ☐ Yes ☐ No

Do you take nutritional supplements or a multivitamin? ☐ Yes ☐ No

My appetite is ☐ Good ☐ Fair ☐ Poor

Review of Systems: Check the appropriate box

	YES	NO
General good health		
Fatigue		
EYES		
Blurred or double vision		
Glaucoma		
Glasses or contacts		
Cataracts		
EAR/ NOSE / THROAT		
Hearing loss / ringing		
Earaches		
Chronic sinus problems		
Nose bleeds		
Sore throat or mouth sores		
Swollen glands in neck		
CARDIOVASCULAR		
Chest pain		
Varicose veins		
Swelling of feet, ankles or hand		
Pacemaker		
RESPIRATORY		
Chronic or frequent coughs		
Spitting up blood		
Shortness of breath		
Asthma or wheezing		
Emphysema		
Tuberculosis		
Sleep apnea		
GASTROINTESTINAL		
Frequent heartburn		
Frequent diarrhea		
Constipation		
Blood in stool		

	YES	NO
GENITOURINARY		
Frequent urination		
Blood in urine		
Female – irregular period		
Kidney Failure		
Dialysis		
MUSCULOSKELETAL		
Joint pain		
Joint stiffness		
Swelling in lower extremities		
Weakness of muscles or joints		
Back pain		
Osteoarthritis		
PSYCHIATRIC		
Memory loss or confusion		
Depression		
Claustrophobia		
Suicide attempt		
ENDOCRINE / HEPATIC		
Glandular / hormone problems		
Thyroid disease		
Excessive thirst or urination		
Heat or cold intolerance		
Hepatitis		
HEMATOLOGIC / LYMPHATIC		
Slow to heal after cuts		
Anemia		
Lymphedema		
HIV		
NEUROLOGICAL		
Frequent / recurring headaches		
Light headed or dizzy		

Thank you for choosing the WHS Wound and Skin Healing Center for your health care needs. We look forward to taking care of you.