Outpatient Wound Care Intake Form

Name:_____ **Phone:**_____

Primary Doctor:_____ **Insurance type:**_____

Primary language spoken:_____ **Do you need an interpreter?** Yes ☐ No ☐

Are you currently receiving Home Health for any reason? Yes ☐ No ☐

Current Symptoms/Chief Complaint: _____

_____

_____

When did your symptoms begin? _____

Causes: **Unknown reason** ☐ **Injury** ☐ **Surgery** ☐

If injury or surgery, please describe: _____

_____

Are the symptoms getting: **Better** ☐ **Worse** ☐ **The same** ☐

Any history with this problem (if yes, please describe)? Yes ☐ No ☐

_____

_____

What was the previous treatment (check all that apply): **Surgery** ☐ **Compression**☐

Skin substitutes ☐ **Pulsed Lavage** ☐ **Dressing changes only** ☐

Other: _____

Did it work? **Yes** ☐ **No** ☐

What are your goals? _____

Previous tests or Surgeries related to <u>this problem</u> (check all that apply):

☐ **Vascular Doppler**	☐ **MRI**	☐ **X ray**	☐ **CAT scan**
☐ **Vein Ablation**	☐ **Biopsy**	☐ **Cultures**	☐ **Skin graft**
☐ **Arterial bypass**	☐ **Amputation**	☐ **Recent Labs**	☐ **Debridement**
☐ **Muscle flap**	**Other:**		

Past Medical History:

What allergies do you have? (Check all that apply).

☐ **None** ☐ **Iodine** ☐ **sulfa drugs** ☐ **Penicillin** ☐ **Tape adhesive**

☐ **Latex** **Other:**

Have you ever been diagnosed with any of the following?

☐ **Implanted Defibrillator**	☐ **Pacemaker**	☐ **Stroke**
☐ **Congestive Heart Failure**	☐ **COPD**	☐ **Emphysema**
☐ **High Blood Pressure**	☐ **Vision problems**	☐ **MRSA**
☐ **Problems with circulation**	☐ **Gangrene**	☐ **Malnutrition**
☐ **Joint Replacement**	☐ **Metal implants**	☐ **Dehydration**
☐ **Rheumatory Arthritis**	☐ **Osteoarthritis**	☐ **Currently pregnant**
☐ **Problems controlling urine**	☐ **Problems controlling bowel**	
☐ **Depression/anxiety**	☐ **Quadraplegia**	☐ **Paraplegia**
☐ **Polio or post polio**	☐ **Decreased Sensation**	☐ **Myelomeningocele**
☐ **Parkinson's Disease**	☐ **HIV**	☐ **AIDS**
☐ **Hepatitis B or C**	☐ **Blood disorders**	☐ **Thyroid disorder**

Cancer: Yes ☐ No ☐

Type:_____

Have you ever had radiation or chemotherapy? _____

Diabetes: Yes ☐ No ☐

If yes, what were your blood sugar levels this morning? _____

If yes, what was your most recent A1C? _____

Kidney disease: Yes ☐ No ☐

If yes, are you currently on dialysis? Yes ☐ or No ☐

Have you noticed any unexplained weight gain or loss due to swelling? Yes☐ No☐

Do you smoke cigarettes, cigars or pipe? Yes ☐ No☐ # of **Packs per Day:** _____

Please list any additional past medical history:

_____

_____

_____

_____

Medication:

Please check any of the medicines you are taking now:

Lasix/Waterpill ☐ Steroids ☐ Chemotherapy ☐

Coumadin/aspirin/blood thinners☐ Antibiotics ☐

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Medicines	Dose	How often taken

Functional Status:

Do you need any help to walk or transfer into a chair? Yes ☐ No☐

Do you use any of the following to help you with mobility (check all that applies):

Cane☐ Walker ☐ Wheelchair/Scooter ☐ Other_____

Who changes your dressings? Self ☐ Spouse ☐ Caregiver ☐ Other:_____

How often are your dressings changed? Once a day☐ Twice a day

☐ Three or more per day ☐ Every other day☐ Once a week ☐ Other:_____

What types of dressing do you use (include topical medications and ointments)?

_____

Are you currently working? Yes ☐ No☐ What type of work do you do?:_____

Pain Profile:

Do you have pain now? Yes ☐ No ☐

Where is your pain located?_____

What is your pain rating from 0 to 10 (0=no pain, 10=worst pain ever)

Now=_____ Worst=_____ Best=_____

How would you describe your pain? (Check all that apply)

☐ Chronic	☐ Continuous	☐ Intermittent	☐ Pressure	☐ Phantom
☐ Sudden	☐ Aching	☐ Sharp	☐ Spasm	☐ Burning
☐ Cramping	☐ Throbbing	☐ Stabbing	☐ Dull	☐ Radiating
☐ Tightness	Other:			

What makes your pain worse? (Check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Sleeping ☐ Laying down

Other:

What relieves your pain? (Check all that apply)

☐ Resting	☐ Heat	☐ Cold	☐ Medications	☐ Sitting
☐ Walking	☐ Standing	☐ Sleeping	☐ Laying Down	
☐ Changing Positions	Other: _____			

Victim Abuse:

Is a partner physically, emotionally or mentally abusing you? Yes ☐ No☐

Is it safe for you to go home? Yes ☐ No☐

Are you at risk of being harmed by anyone close to you? Yes ☐ No☐

Would you like any information on community services available to you in regard to the above asked questions? Yes☐ No ☐

Advanced Directives:

Do you have advanced directives such as: a Living Will, a Power of Attorney for Health Care, Five Wishes, or Illinois Department of Public Health Universal DNR Advance Directive? Yes☐ No ☐

Nutrition:

Is your wound non-healing/or has not improved in the past 3 weeks?

Yes ☐ No☐

Have you lost weight over the past few weeks? Yes☐ No☐

Height: _____ Weight: _____

Can you drink milk? Yes ☐ No ☐

Are you on a special diet? Yes ☐ No ☐

If yes, please describe: _____

Please check each statement that is true for you:

☐ **I have an illness or condition that has made me change the kind and/or amount of food that I eat**

☐ **I eat fewer than 2 meals a day**

☐ **I eat less than 3 servings of fruit, vegetables or milk products per day**

☐ **I have 3 or more drinks of beer, wine and/or liquor almost everyday**

☐ **I have mouth problems or teeth problems which make it difficult for me to eat**

☐ **I don't always have enough money to buy food**

☐ **I live alone and/or eat alone**

☐ **I take medicines which decrease my appetite and/or food intake**

☐ **Without trying, I have lost or gained more than 10 pounds**

☐ **I am not physically able to cook, shop and/or feed myself**

Are there any barriers to your treatment?

Transportation ☐ Financial ☐ Environmental☐ Social☐

Please explain: _____

How do you learn best?

Pictures ☐ Reading ☐ Listening ☐ Watching ☐ Other: _____

Do you have any specific customs, wishes or religious beliefs that might affect care?_____

_____

_____