

NEW PATIENT MEDICAL HISTORY

CHIEF COMPLAINT: (WHAT IS THE REASON FOR YOUR VISIT TODAY?)

HISTORY OF PRESENT ILLNESS:

LOCATION: (WHERE IS YOUR WOUND LOCATED?)

DURATION: (HOW LONG HAVE YOU HAD THE WOUND?)

CONTEXT: (HOW DID YOUR WOUND OCCUR OR DEVELOP?)

ASSOCIATED SIGNS/SYMPTOMS: DESCRIBE ANY SIGNS OR SYMPTOMS OF YOUR WOUND (SUCH AS, DRAINAGE, ODOR, NUMBNESS, ETC.)

TIMING: (DO YOU HAVE PAIN IN OR AROUND THE WOUND?) No Yes

IF YES, IS THE PAIN CONSTANT (*HURTS ALL THE TIME*) OR INTERMITTENT (*COMES AND GOES*)?

QUALITY: (DESCRIBE YOUR PAIN BY CHECKING ALL THAT APPLY BELOW)

- ACHING BURNING THROBBING STABBING SHOOTING SHARP DULL HEAVY
 CRAMPING EXHAUSTING SPLITTING TENDER EASY TO PINPOINT DIFFICULT TO PINPOINT

MODIFYING FACTORS: (DESCRIBE OR LIST ANY CONDITIONS OR ACTIVITIES THAT IMPACT YOUR WOUND, SUCH AS PAIN WHEN WALKING OR RAISING YOUR LEG)

** HAS YOUR WOUND EVER HEALED AND THEN RE-OPENED? No Yes

** HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH? No Yes; IF YES, WHERE: _____

** HAVE YOU HAD ANY TESTS FOR CIRCULATION IN YOUR LEGS? No Yes; IF YES, WHERE: _____

** WHO ORDERED ABOVE TESTS? LAB _____ CIRCULATION: _____

** HOW HAVE YOU BEEN TAKING CARE OF YOUR WOUND?

** INFORMATION IS NOT COLLECTED IN THE CLINICAL DATABASE

Orthopnea (shortness of breath when lying down)			
Palpitations			
MEDICAL HISTORY	YES	NO	COMMENTS
Congestive Heart Failure			
Coronary Artery Disease (CAD)			
Deep Vein Thrombosis (clot in the vein)			
Hyperlipidemia (High cholesterol)			
Hypertension (High blood pressure)			
Murmur			
Myocardial Infarction (Heart attack)			
Peripheral Vascular Disease			
Rheumatic Fever			
Vasculitis			
SURGICAL HISTORY	YES	NO	COMMENTS
Coronary Artery Bypass Surgery			
Greenfield Filter			
Left Ventricular Assist Device			
Pacemaker/Defibrillator			
Peripheral Bypass surgery			
Stent Placement			
Subfascial endoscopic perforator surgery (SEPS)			
Valve Replacement			
Vein Stripping			
EAR / NOSE / MOUTH / THROAT			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Hearing Loss / Aid			
Otalgia (ear ache)			
Dental Problems			
Painful or Swollen Lymph Nodes			
MEDICAL HISTORY	YES	NO	COMMENTS
Barotrauma (damage to ear drum)			
Sinusitis			
Tinnitus (ringing in ears)			
SURGICAL HISTORY	YES	NO	COMMENTS
Myringotomy (incision in eardrum)			
Tube Placement (in ear)			
EYES			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Blurred Vision			
Dry Eyes			
Vision Changes			
Glasses / Contacts			
MEDICAL HISTORY	YES	NO	COMMENTS
Cataracts			
Glaucoma			
Retinopathy (damage to the retina)			
SURGICAL HISTORY	YES	NO	COMMENTS
Other			
ENDOCRINE			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cold Intolerance			

Heat Intolerance			
Polydypsia (Excessive thirst)			
Polyuria (Excessive urination)			
MEDICAL HISTORY	YES	NO	COMMENTS
Gestational Diabetes (with pregnancy)			
Thyroid Disease			
Type 1 Diabetes (insulin dependent)			
Type 2 Diabetes (adult onset)			
GASTROINTESTINAL (GI)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Bowel Incontinence			
Change in Bowel Habits			
Jaundice			
Nausea / Vomiting / Diarrhea			
Loss of Appetite			
MEDICAL HISTORY	YES	NO	COMMENTS
Cirrhosis of the Liver			
Crohn's Disease			
Gastro Esophageal Reflux (GERD)			
Hepatitis (liver infection)			
Special Diet			
Ulcerative Colitis			
SURGICAL HISTORY	YES	NO	COMMENTS
Colectomy (remove part large colon)			
Colostomy			
Ileostomy			
GENITOURINARY (GU)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Frequency			
Urinary Incontinence			
Pregnant			
MEDICAL HISTORY	YES	NO	COMMENTS
Benign Prostate Hyperplasia			
Dialysis			
End Stage Renal Disease			
Kidney Disease			
Miscarriage			
Prostate Cancer			
Sexually Transmitted Disease			
SURGICAL HISTORY	YES	NO	COMMENTS
Previous OB/GYN Surgery			
HEMATOLOGIC / LYMPHATIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Bruising			
Bleeding / Clotting Disorders			
Blood Transfusion			
MEDICAL HISTORY	YES	NO	COMMENTS
Anemia			
Anticoagulant Therapy			
Lymphedema			
Sickle Cell Anemia			
INTEGUMENTARY (HAIR / SKIN / NAILS)			

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Pruritis (Itching)			
Rash			
Skin Allergies			
Calluses/Corns			
Prone to Skin Tears			
MEDICAL HISTORY	YES	NO	COMMENTS
Malignancy (skin cancer)			
Onchomycosis (nail fungal infection)			
Scleroderma			
MUSCULOSKELETAL			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Backache			
Contractures			
Deformities			
Muscle Pain			
Muscle Wasting			
Muscle Weakness			
Assistive Devices			
MEDICAL HISTORY	YES	NO	COMMENTS
Arthritis			
Gout			
Hip Fracture			
Osteoarthritis			
Osteomyelitis (bone infection)			
Osteoporosis			
Other Fracture			
SURGICAL HISTORY	YES	NO	COMMENTS
Achilles Tendon Lengthening			
Amputation			
Back Surgery			
Foot Surgery			
Implanted Surgical Hardware			
Joint Replacement			
NEUROLOGICAL			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Abnormal Gait			
Dizziness			
Loss of Protective Sensation			
Numbness			
Tingling			
Tremors			
Vertigo (dizziness)			
Weakness			
Headaches			
Paralysis			
Seizures			
Syncope (brief fainting episode)			
MEDICAL HISTORY	YES	NO	COMMENTS
Amyotrophic Lateral Sclerosis (ALS)			
Brain or Spinal Cord Trauma Injury			
Epilepsy			
Head Injury / Loss of Consciousness			
Multiple Sclerosis			

Stroke			
Transient Ischemic Attack (TIA)			
PSYCHIATRIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Anxiety			
Claustrophobia			
Insomnia			
Nervousness / Tension			
Memory Loss			
MEDICAL HISTORY	YES	NO	COMMENTS
Alzheimer's			
Dementia (loss of mental skills)			
Depression			
RESPIRATORY			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cough			
Hemoptysis (coughing blood)			
Shortness of Breath			
Wheezing			
Oxygen in Use			
MEDICAL HISTORY	YES	NO	COMMENTS
Abnormal Chest X-ray			
Asthma			
Chronic Obstructive Pulmonary Disease (COPD)			
Emphysema			
Pneumonia			
Pneumothorax (collapsed lung)			
Positive TB Test			
Pulmonary Embolus (blood clot in lung)			
Tuberculosis			
Upper Respiratory Infection (URI)			
ONCOLOGIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cancer			Type:
Receiving Chemotherapy			
Receiving Radiation			
MEDICAL HISTORY	YES	NO	COMMENTS
Cancer			Type:
Received Chemotherapy			
Received Radiation			
Type of Cancer			
FAMILY & SOCIAL HISTORY			
FAMILY HISTORY	YES	NO	COMMENTS
Cancer			
Diabetes			Type I: _____ Type II: _____ Date Onset: _____
Heart Disease			
Hypertension			
Kidney Disease			
Lung Disease			
Mental Illness			
Seizures			
Stroke			
Thyroid Problems			
Tuberculosis			

Social History			
Substance Abuse <input type="checkbox"/> No <input type="checkbox"/> Yes DESCRIBE:			
Alcohol Use: <input type="checkbox"/> NEVER <input type="checkbox"/> RARELY <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY			
Tobacco Use: <input type="checkbox"/> NEVER <input type="checkbox"/> FORMER <input type="checkbox"/> LESS THAN 1 PACK PER DAY <input type="checkbox"/> GREATER THAN 1 PACK PER DAY			
Smokeless Tobacco Use: <input type="checkbox"/> NEVER <input type="checkbox"/> RARELY <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY			
Caffeine Use: <input type="checkbox"/> NEVER <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> CURRENTLY TYPE / FREQUENCY:			
Illicit Drug Use: <input type="checkbox"/> NEVER <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> CURRENTLY TYPE / FREQUENCY:			
Occupation:			
Marital Status <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER:			
Children <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, HOW MANY:			
Cultural, Religious or Language Preference:			
Support Systems Lacking:			
Transport Concerns:			
Unable to Care for Self: <input type="checkbox"/> No <input type="checkbox"/> Yes DESCRIBE:			
MEDICATIONS - - WRITE ON BACK IF MORE ROOM NEEDED			
<i>[PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING - - INCLUDE OVER THE COUNTER, HERBAL & VITAMIN SUPPLEMENTS]</i>			
ARE YOU ON ANY MEDICATION THAT AFFECTS YOUR BALANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
MEDICATIONS	AMOUNT / DOSAGE	HOW OFTEN	
NUTRITION ASSESSMENT / SCREEN			
HISTORY	YES	NO	ACTION PLAN
Difficulty Chewing or Swallowing [1]			
Do You Need Assistance with Eating [1]			
Have You Had a Weight Loss or Gain > 10 lbs in Past 6 Months [2]			
If Yes, _____ lbs in _____ months			Reason, if known:
Intentional Weight Loss from Program or Medications [1]			
Do You Follow a Special Diet [1]			
Do You Have Any Food Allergies [1]			
Do You Have a Good Appetite [0]			
Do You Have a Fair Appetite [1]			
Do You Have a Poor Appetite [2]			
Do You Take Nutritional Supplements [0]			
Do You Drink Several 8 oz Glasses of Water Each Day [0]			
RISK LEVEL: Low = less than or equal to 2 High = greater than 3 (Staff Use Only)			SCORE:
GENERAL NOTES			

PATIENT SIGNATURE: _____ **DATE:** _____ **TIME:** _____
(OR LEGAL GUARDIAN/POA)

I HAVE REVIEWED THE NEW PATIENT MEDICAL HISTORY WITH THE PATIENT / CAREGIVER AS PART OF THE INITIAL NURSING ASSESSMENT.

NURSE SIGNATURE: _____ **DATE:** _____ **TIME:** _____