

MACOMB/CLINTON CENTER FOR WOUND & HYPERBARIC MEDICINE
PATIENT HISTORY

Today's Date _____

▪ **GENERAL INFORMATION**

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Sex _____ SSN _____

What Physician suggested you visit the Wound Healing Center ?

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip _____

Who is your primary physician ?

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip _____

Home Health Care _____ *Pharmacy* _____

Nursing Home _____ *Equipment at Home* _____

Have you ever been a patient at _____ *?* _____

How did you learn of the Wound Healing Center

(Please check all that apply)

- T.V.**
- Newspaper**
- Radio**
- Physician**
- Nurse**
- Friend/Relative**
- Other** _____

▪ **EMPLOYMENT INFORMATION**

Employer _____ Retirement Date _____

Employer Address _____ City _____ State _____ Zip _____

Spouse/Nearest Relative _____

Spouse Date of Birth _____ Spouse Social Security Number _____

Spouse Address _____ Spouse Phone # _____

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Spouse Employer _____ Spouse Retirement Date _____

Spouse Employer Address _____ City _____ State _____ Zip _____

Spouse Insurance Company _____ Policy Number _____

Is this wound covered by Workers Compensation? Yes _____ No _____

▪ **WOUND HISTORY**

Wound location _____

How did your wound start ? _____

Is your wound open and draining ? _____

When did you first notice the wound? _____

Is your wound painful? Yes _____ No _____

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

Has it ever healed and then reopened ? Yes _____ No _____

How have you been treating your wound until now? _____

Have you had any lab work done in the past month? Yes _____ No _____ Who Ordered _____

Have you had any tests for circulation on your legs? Yes _____ No _____ Where done _____
 Who ordered _____

That you know of, have you ever had any other problems associated with your wound?
 Infection Swelling (Please circle) Other _____

▪ **MEDICAL HISTORY**

| | PATIENT | | FAMILY | | EXPLAIN (Who, Age) |
|----------------------|---------|----|--------|----|-----------------------|
| Diabetes | Yes | No | Yes | No | |
| Hypertension | Yes | No | Yes | No | |
| Cancer | Yes | No | Yes | No | |
| Stroke | Yes | No | Yes | No | |
| Bleeding tendency | Yes | No | Yes | No | |
| Acute infections | Yes | No | Yes | No | |
| Hereditary defects | Yes | No | Yes | No | |
| Heart trouble | Yes | No | Yes | No | |
| Arthritis/gout | Yes | No | Yes | No | |
| Convulsions/Seizures | Yes | No | Yes | No | |

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▪ **SYSTEM REVIEW** (Please circle yes or no for each item)

GENERAL SYMPTOMS

| | | |
|----------------------------|-----|----|
| Good general health lately | Yes | No |
| Recent weight change | Yes | No |
| Fever | Yes | No |
| Fatigue | Yes | No |
| Headaches | Yes | No |
| Height _____ Weight _____ | | |

EYES

| | | |
|--------------------------|-----|----|
| Blurred or double vision | Yes | No |
| Glaucoma | Yes | No |
| Wear glasses or contacts | Yes | No |
| Cataracts | Yes | No |

EARS/NOSE/MOUTH/THROAT

| | | |
|------------------------------------|-----|----|
| Hearing loss or ringing | Yes | No |
| Earaches or drainage | Yes | No |
| Chronic sinus problems or rhinitis | Yes | No |
| Nose bleeds | Yes | No |
| Mouth sores | Yes | No |
| Sore throat or voice change | Yes | No |
| Swollen glands in neck | Yes | No |

CARDIOVASCULAR

| | | |
|-----------------------------------|-----|----|
| Chest Pain | Yes | No |
| Swelling of feet, ankles or hands | Yes | No |
| Pacemaker | Yes | No |

RESPIRATORY

| | | |
|----------------------------|-----|----|
| Chronic or frequent coughs | Yes | No |
| Spitting up blood | Yes | No |
| Shortness of breath | Yes | No |
| Asthma or wheezing | Yes | No |
| Emphysema | Yes | No |
| Tuberculosis | Yes | No |

GASTROINTESTINAL

| | | |
|-------------------------|-----|----|
| Loss of appetite | Yes | No |
| Nausea or vomiting | Yes | No |
| Frequent diarrhea | Yes | No |
| Painful bowel movements | Yes | No |
| Constipation | Yes | No |
| Blood in Stool | Yes | No |

MUSCULOSKELETAL

| | | |
|-------------------------------|-----|----|
| Joint Pain | Yes | No |
| Joint stiffness or swelling | Yes | No |
| Weakness of muscles or joints | Yes | No |
| Back Pain | Yes | No |
| Cold extremities | Yes | No |
| Difficulty in walking | Yes | No |
| Arthritis | Yes | No |

INTEGUMENTARY (Skin)

| | | |
|-----------------|-----|----|
| Rash or itching | Yes | No |
| Varicose veins | Yes | No |
| Change in mole | Yes | No |

NEUROLOGICAL

| | | |
|-------------------------------|-----|----|
| Frequent /recurring headaches | Yes | No |
| Light headed or dizzy | Yes | No |
| Convulsions or seizures | Yes | No |
| Poor sensation in feet | Yes | No |
| Paralysis | Yes | No |
| Stroke | Yes | No |

PSYCHIATRIC

| | | |
|--------------------------|-----|----|
| Memory loss or confusion | Yes | No |
| Depression | Yes | No |
| Claustrophobia | Yes | No |

ENDOCRINE

| | | |
|-------------------------------|-----|----|
| Glandular or hormone problems | Yes | No |
| Thyroid disease | Yes | No |
| Diabetes | Yes | No |
| Excessive thirst or urination | Yes | No |
| Heat or cold intolerance | Yes | No |

HEMATOLOGIC/LYMPHATIC

| | | |
|-------------------------------|-----|----|
| Slow to heal after cuts | Yes | No |
| Bleeding or bruising tendency | Yes | No |
| Anemia | Yes | No |
| Phlebitis | Yes | No |

GENITOURINARY

| | | |
|----------------------------|-----|----|
| Frequent urination | Yes | No |
| Burning/painful urination | Yes | No |
| Blood in urine | Yes | No |
| Incontinence/dribbling | Yes | No |
| Female – irregular periods | Yes | No |
| Female – Pregnancies | Yes | No |
| Kidney failure | Yes | No |
| Dialysis | Yes | No |

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▪ **SOCIAL HISTORY**

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

Tobacco Use: Never _____ Previously, but quit _____ Current packs/day _____

Alcohol Use: Never _____ Rarely _____ Moderate _____ Daily _____

Drug Use: Never _____ Type/Frequency _____

Caffeine Use: Never _____ Type/Frequency _____

▪ **CURRENT HEALTH STATUS** (Please check one for each item)

| | | | |
|----------------------------|-------------------------------|-------------------------------|---------------------------------|
| Body Pain | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> Severe |
| Wound Pain | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> Severe |
| Energy | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> High |
| Physical Role Limitations | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> Severe |
| Emotional Role Limitations | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> Severe |
| Physical Functioning | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> High |
| Social Functioning | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> High |
| Mental Health | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Bad |
| Health Perception | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Bad |

▪ **ACTIVITIES OF DAILY LIVING** (Please check one for each item)

| | | | |
|---------------------|--|---|-----------------------------------|
| Care for Appearance | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Use Toilet | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Bath/Shower | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Dress Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Feed Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Walk | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Get in/out bed | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Housework | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Prepare Meals | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Handle Money | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Take Medications | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Shop for Self | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |
| Use telephone | <input type="checkbox"/> Completely Able | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Not Able |

▪ **MEDICARE** (Only fill out if currently receiving Medicare)

Have you ever received a kidney transplant _____ Date Received _____

Do you participate in a Dialysis Program _____ Date started _____

Do you participate in a Black Lung program _____

Are services covered under a government program, such as a research grant _____

Are you entitled to any Veteran's Administration (VA) benefits _____

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- **IMMUNIZATION RECORD** (10 years old or younger only)

| IMMUNIZATION | DATE RECEIVED |
|--------------|---------------|
| | |
| | |
| | |

- **WHEN WAS THE DATE OF YOUR LAST TETANUS VACCINATION?** _____

- **NUTRITION PROFILE**

| | | |
|---|-----|----|
| Difficulty chewing or swallowing | Yes | No |
| Do you need assistance with eating | Yes | No |
| Have you had a large weight loss or gain (<i>Please circle loss <u>or</u> gain</i>) | Yes | No |
| If yes, _____lbs in _____months | | |
| Reason, if known _____ | | |
| Special Diet | Yes | No |
| Please explain _____ | | |
| Food allergies | Yes | No |
| Please explain _____ | | |
| Are you involved in weight loss program | Yes | No |
| Appetite: Good Fair Poor (<i>Please circle one</i>) | | |
| How many meals do you eat each day _____ | | |
| Do you take vitamins or other supplements | Yes | No |
| Please explain _____ | | |
| How much water do you drink each day _____glasses | | |
| Do you exercise regularly | Yes | No |

Patient Signature _____ Date _____