

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 (<i>shortness of breath when lying down</i>)			
Palpitations			
MEDICAL HISTORY	YES	NO	COMMENTS
Congestive Heart Failure			
Coronary Artery Disease (<i>CAD</i>)			
Deep Vein Thrombosis (<i>clot in the vein</i>)			
Hyperlipidemia (<i>High cholesterol</i>)			
Hypertension (<i>High blood pressure</i>)			
Murmur			
Myocardial Infarction (<i>Heart attack</i>)			
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 (<i>SEPS</i>)			
Valve Replacement			
Vein Stripping			
EAR / NOSE / MOUTH / THROAT			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Hearing Loss / Aid			
Otalgia (<i>ear ache</i>)			
Dental Problems			
Painful or Swollen Lymph Nodes			
MEDICAL HISTORY	YES	NO	COMMENTS
Barotrauma (<i>damage to ear drum</i>)			
Sinusitis			
Tinnitus (<i>ringing in ears</i>)			
SURGICAL HISTORY	YES	NO	COMMENTS
Myringotomy (<i>incision in eardrum</i>)			
Tube Placement (<i>in ear</i>)			
EYES			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Blurred Vision			
Dry Eyes			
Vision Changes			
Glasses / Contacts			
MEDICAL HISTORY	YES	NO	COMMENTS
Cataracts			
Glaucoma			
Retinopathy (<i>damage to the retina</i>)			
SURGICAL HISTORY	YES	NO	COMMENTS
Other			
ENDOCRINE			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cold Intolerance			

Heat Intolerance			
Polydypsia (<i>Excessive thirst</i>)			
Polyuria (<i>Excessive urination</i>)			
MEDICAL HISTORY	YES	NO	COMMENTS
Gestational Diabetes (<i>with pregnancy</i>)			
Thyroid Disease			
Type 1 Diabetes (<i>juvenile onset</i>)			
Type 2 Diabetes (<i>adult onset</i>)			
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 (<i>GERD</i>)			
Hepatitis (<i>liver infection</i>)			
Special Diet			
Ulcerative Colitis			
SURGICAL HISTORY	YES	NO	COMMENTS
Colectomy (<i>remove part large colon</i>)			
Colostomy			
Ileostomy			
GENITOURINARY (GU)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Frequency			
Urinary Incontinence			
Pregnant			
MEDICAL HISTORY	YES	NO	COMMENTS
Benign Prostate Hyperplasia (<i>enlarged prostate</i>)			
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 (<i>low blood count</i>)			
Anticoagulant Therapy			
Lymphedema			
Sickle Cell Anemia			
INTEGUMENTARY (HAIR / SKIN / NAILS)			

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Pruritis (<i>Itching</i>)			
Rash			
Skin Allergies			
Calluses/Corns			
Prone to Skin Tears			
MEDICAL HISTORY	YES	NO	COMMENTS
Malignancy (<i>skin cancer</i>)			
Onchomycosis (<i>nail fungal infection</i>)			
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 (<i>bone infection</i>)			
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 (<i>dizziness</i>)			
Weakness			
Headaches			
Paralysis			
Seizures			
Syncope (<i>brief fainting episode</i>)			
MEDICAL HISTORY	YES	NO	COMMENTS
Amyotrophic Lateral Sclerosis (<i>ALS</i>)			
CNS Trauma Injury			
Epilepsy			
Head Injury / LOC			
Multiple Sclerosis			

Stroke			
Transient Ischemic Attack (TIA / mini-stroke)			
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 YEARS:
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 Concerns:			
Support Systems Lacking:			
Transportation Concerns (able to drive, etc.)?:			
Able to Care for Self (dressing, bathing, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes If "No", explain :			
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>			
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:** _____