PATIENT:______________________________

NEW PATIENT MEDICAL HISTORY

CHIEF COMPLAINT

WHAT IS THE REASON FOR YOUR VISIT TODAY?

HPI

TELL US ABOUT YOUR WOUNDS:

Where is your wound located? ______________________________

How long have you had the wound(s)? ______________________________

How did the wound(s) occur or develop? ______________________________

Describe any signs or symptoms associated with your wound (odor, numbness, drainage, etc…):

____

On scale of 1 – 10, with 10 being the worst, how do you rate your pain: ________________
Describe your pain by checking the boxes, below, that apply.

☐ Constant (never goes away) ☐ Intermittent (comes and goes)

☐ Aching ☐ Burning ☐ Throbbing ☐ Stabbing ☐Shooting ☐ Sharp ☐ Dull ☐ Heavy

☐ Cramping ☐ Tender ☐ Easy to pinpoint ☐ Difficult to pinpoint

Describe or list any conditions or activities that impact your wound, such as pain when walking or raising your leg:

____

REVIEW OF SYSTEMS *[LIST ALL OF YOUR **CURRENT** COMPLAINTS AND SYMPTOMS]*

CONSTITUTIONAL (GENERAL HEALTH)			EYES		
CURRENT COMPLAINTS & SYMPTOMS	**YES**	**NO**	**CURRENT COMPLAINTS & SYMPTOMS**	**YES**	**NO**
Chills			Blurred Vision		
Fatigue *(tired all of the time)*			Dry eyes		
Fever			Glasses/Contacts		
Loss of Appetite			Vision Changes		
Marked Weight Change			Eye Pain		
Night Sweats			Other		
Other					
EAR / NOSE / MOUTH / THROAT			**RESPIRATORY**		
Dental Problems			Cough		
Hearing Loss/Aid			Hemoptysis *(coughing blood)*		
Nasal Congestion			Shortness of Breath		
Painful or Swollen Lymph Nodes			Wheezing		
Sore Throat			Oxygen in Use		
Other			Other		
CARDIOVASCULAR (CENTRAL / PERIPHERAL)			**GASTROINTESTINAL (GI)**		
Chest Pain			Acid Reflux		
Diaphoresis			Bowel Incontinence		
Dyspnea on Exertion			Change in Bowel Habits		
Edema			Constipation		
Intermittent Claudication			Diarrhea		

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Current Complaints & Symptoms	Yes	No	Current Complaints & Symptoms	Yes	No
Lower extremity (leg) resting pain			Jaundice		
Lower extremity (leg) swelling			Loss of Appetite		
Orthopnea			Nausea/Vomiting/Diarrhea (N/V/D)		
Palpitations			Stomach/Abdominal pain		
Current Complaints & Symptoms	**Yes**	**No**	**Current Complaints & Symptoms**	**Yes**	**No**
Syncope			Blood in Stool		
Other			Other		
Genitourinary (GU)			**Endocrine**		
Frequency			Cold Intolerance		
Pregnant			Heat Intolerance		
Urgency			Polydypsia (Excessive Thirst)		
Urinary Incontinence			Polyuria (Excessive Urination)		
Other			Other		
Neurological			**Integumentary (Hair/Skin/Nails)**		
Abnormal Gait			Change: Hair, Nails, Skin		
Dizziness			Dryness		
Headaches			Calluses/Corns		
Loss of Protective Sensation			Change in Moles		
Numbness			Hemosiderin Staining		
Paralysis			Hyperpigmentation		
Seizures			Itching		
Syncope			Lesions		
Tingling			Rash		
Tremors			Prone to Skin Tears		
Weakness			Sun Sensitivity		
Other			Other		
Musculoskeletal			**Psychiatric**		
Decreased Activity			Anxiety		
Joint Pain			Claustrophobia		
Joint Swelling			Depression		
Assistive Devices			Memory Loss		
Backache			Nervousness/Tension		
Contractures			Suicidal		
Deformities			Other		
Muscle Pain					
Muscle Wasting					
Muscle Weakness					
Other					
Allergic / Immunologic			**Hematologic/Lymphatic**		
Frequent Rashes			Bleeding/ Clotting disorders		
Hay Fever			Blood Transfusions		
Hives			Bruising		
Rhinitis			Enlarged Lymph Nodes		
Recurrent Fevers			Swelling		
Other			Other		

PAST MEDICAL & SURGICAL HISTORY

	Yes	No		Yes	No
Constitutional (General Health)					
Implantable port or intravenous catheter (Portacath or PICC line)			History of VRE or MRSA		
Ear / Nose / Mouth / Throat					
Barotrauma *(damage to ear drum)*			Myringotomy *(incision in eardrum)*		
Sinusitis			Tube Placement *(in ear)*		

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Tinnitus *(ringing in ears)*					
EYES					
Cataracts			Cataract repair		
Glaucoma			Eyes surgery		
Retinopathy *(damage to the retina)*			Prosthetic eye		
RESPIRATORY					
Abnormal Chest X-ray			Pneumonia		
Asthma			Pneumothorax *(collapsed lung)*		
Chest tube insertion			Positive TB Test		
Chronic Obstructive Pulmonary Disease *(COPD)*			Pulmonary Embolus *(blood clot in lung)*		
Emphysema			Thoracic surgery		
Lung resection			Tuberculosis		
Lung transplant			Upper Respiratory Infection *(URI)*		
CARDIOVASCULAR (CENTRAL / PERIPHERAL)					
Congestive Heart Failure			Coronary Artery Bypass Surgery		
Coronary Artery Disease *(CAD)*			Greenfield Filter		
Deep Vein Thrombosis *(clot in the vein)*			Left Ventricular Assist Device		
Hyperlipidemia *(High cholesterol)*			Pacemaker/Defibrillator		
Hypertension *(High blood pressure)*			Peripheral Bypass surgery		
Murmur			Stent Placement		
Myocardial Infarction *(Heart attack)*			Valve Replacement		
Peripheral Vascular Disease			Vasculitis		
Rheumatic Fever			Venous insufficiency		
Subfascial endoscopic perforator surgery *(SEPS)*			Vein Stripping		
GASTROINTESTINAL (GI)					
Cirrhosis of the Liver			Colectomy *(remove part large colon)*		
Crohn's Disease			Colostomy		
Gastro Esophageal Reflux *(GERD)*			Ileostomy		
Hepatitis *(liver infection)*			Appendectomy		
Special Diet			Fistula repair		
Ulcerative Colitis			Gastric bypass or lap band		
GENITOURINARY (GU)					
Benign Prostate Hyperplasia *(enlarged prostate)*			Miscarriage		
Dialysis			Prostate Cancer		
End Stage Renal Disease			Previous OB/GYN Surgery		
Kidney Disease			Sexually Transmitted Disease		
ENDOCRINE					
Gestational Diabetes *(with pregnancy)*			Type 1 Diabetes *(juvenile onset)*		
Thyroid Disease			Type 2 Diabetes *(adult onset)*		
MUSCULOSKELETAL					
Achilles Tendon Lengthening			Implanted Surgical Hardware		
Amputation			Joint Replacement		
Arthritis			Osteoarthritis		
Back Surgery			Osteomyelitis *(bone infection)*		
Foot Surgery			Osteoporosis		
Gout			Other Fracture		
Hip Fracture					
INTEGUMENTARY (HAIR / SKIN / NAILS)					
Burn			Onchomycosis *(nail fungal infection)*		
Malignancy *(skin cancer)*			Scleroderma		
NEUROLOGICAL					

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Amyotrophic Lateral Sclerosis *(ALS)*			HEAD/SPINAL SURGERY		
CNS Trauma Injury			Multiple Sclerosis		
Epilepsy			Stroke		
Head Injury / LOC			Transient Ischemic Attack *(TIA / mini-stroke)*		
PSYCHIATRIC					
Alzheimer's			Depression		
Dementia *(loss of mental skills)*					
HEMATOLOGIC / LYMPHATIC					
Anemia *(low blood count)*			Lymphedema		
Anticoagulant Therapy			Sickle Cell Anemia		
ALLERGIC / IMMUNOLOGIC					
AIDS / HIV			Reynaud's Disease		
Lupus			Rheumatoid Arthritis		
Pyoderma Gangrenosum					

FAMILY HISTORY

Condition:	Mother	Maternal GPs	Father	Paternal GPs	Sibling	Child	No History	NOTES
Cancer								
Diabetes Type I: _____ Type II: _____								
Heart Disease								
Hypertension								
Kidney Disease								
Lung Disease								
Mental Illness								
Seizures								
Stroke								
Thyroid Problems								
Tuberculosis								

SOCIAL HISTORY

Smoking Status:	☐ Current every Day ☐ NEVER ☐ Current some Day ☐ FORMER ☐ Current Status Unknown ☐ Unknown if ever smoked ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker
Substance Abuse	☐ NO ☐ YES | DESCRIBE:
Alcohol Use:	☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY
Smokeless Tobacco:	☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY
Caffeine Use:	☐ NEVER ☐ PREVIOUSLY ☐ CURRENTLY | TYPE / FREQUENCY:
Illicit Drug Use:	☐ NEVER ☐ PREVIOUSLY ☐ CURRENTLY | TYPE / FREQUENCY:
Occupation:	
Marital Status	☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:
Children	☐ NO ☐ YES | IF YES, HOW MANY:
Cultural, Religious or Language Concerns that may affect your care:	
Financial Concerns:	
Do family and friends provide help when needed?	☐ NO ☐ YES

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Support Systems Lacking: ☐ No ☐ Yes

Transportation Concerns (able to drive, etc.)?:

Able to Care for Self (dressing, bathing, etc.)? ☐ No ☐ Yes If "No", explain :

Do you currently have Home Care or Hospice? ☐ No ☐ Yes If "Yes", explain :

Assisted Living: ☐ No ☐ Yes Long Term Care Facility: ☐ No ☐ Yes SNF: ☐ No ☐ Yes Lives with:

No signs of Abuse: ☐

Suspected Abuse or Neglect: ☐ No ☐ Yes CONCERNS:

Suspected Suicide Risk: ☐ No ☐ Yes CONCERNS:

ADVANCED DIRECTIVES & INSTRUCTIONS: *[Check all that apply]*

☐ I Have an Advance Directive	☐ Advance Directive Materials Were Provided to me
☐ I Have A Living Will	☐ I Have A Copy of My Living Will for the Hospital
☐ I Have A Durable Power of Attorney for Healthcare	☐ I Do Not Want to be Resuscitated

ALLERGIES *[List all known allergies and reactions]*

☐ **No Known Allergies** ☐ Latex / Rubber ☐ Tape ☐ Iodine

FOOD ALLERGIES:

MEDICATION ALLERGIES:

OTHER:

MEDICATIONS *[List all medicines you are currently taking - - Include over the counter, herbal & vitamin supplements]*

Write on Back if more room needed

Medication	**Amount**	**Dosage**	**How Often**
EXAMPLE: *ASPIRIN*	*325MG*	*1 PILL*	*DAILY*

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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: __________