

New Patient Medical History

CHIEF COMPLAINT

What is the reason for your visit today? _____

Who is your primary care provider? _____

What pharmacy do you use? _____

Do you currently have a home health or hospice agency caring for you? y n

if yes what agency? _____

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?_____

What have you been doing to treat your wound?

Are your wounds the result of an accident? Y N if yes, date of accident _____

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

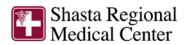
On scale of 1 – 10, with 10 being the worst, how do you rate your pain: ______ Describe your pain by checking the boxes, below, that apply.

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:

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
ARE ANY OF THESE DOCUMENTS ON FILE WITH SRMC? Y N	



ALLERGIES [LIST ALL KNOWN ALLERGIES AND REACTIONS]

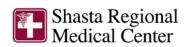
 Image: No Known Allergies
 Image: Tape
 Iodine

 FOOD Allergies:
 Image: Tape
 Iodine

 OTHER:
 Image: Tape
 Iodine

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



New Patient Medical History

PATIENT:_____

REVIEW OF SYSTEMS [list all of your current complaints and symptoms]

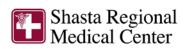
CONSTITUTIONAL (GENERAL HEALTH)			Eyes			
CURRENT COMPLAINTS & SYMPTOMS	Yes	No	CURRENT COMPLAINTS & SYMPTOMS	Yes	No	
Chills			Blurred Vision			
Fatigue (tired all of the time)			Dry eyes			
Fever			Glasses/Contacts			
Loss of Appetite			Vision Changes			
Marked Weight Change			Eye Pain			
Night Sweats			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 / PERIPHERA	L)		GASTROINTESTINAL (GI)			
Chest Pain			Acid Reflux			
Diaphoresis (Sweating)			Bowel Incontinence			
Dyspnea on Exertion			Change in Bowel Habits			
Edema			Constipation			
Intermittent Claudication			Diarrhea			
Lower extremity (leg) resting pain			Jaundice			

New Patient Medical History

PATIENT:____

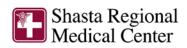
REVIEW OF SYSTEMS CONTINUED [list all of your current complaints and symptoms]

CONSTITUTIONAL (GENERAL HEALTH) GASTROINTESTINAL (GI)					
CURRENT COMPLAINTS & SYMPTOMS	Yes	No	CURRENT COMPLAINTS & SYMPTOMS	Yes	No
Orthopnea			Nausea/Vomiting/Diarrhea (N/V/D)		
Palpitations			Stomach/Abdominal pain		
Syncope (Fainting)			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	5)	
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					



PAST MEDICAL HISTORY

CONSTITUTIONAL (GENERAL HEALTH)					
	Yes	No		Yes	No
			History of VRE or MRSA		
Ear /	Ear / Nose / Mouth / Throat				
Barotrauma (damage to ear drum)					
Sinusitis			Tube Placement (in ear)		
Tinnitus (ringing in ears)					
		Eyes			
Cataracts			Cataract repair		
Glaucoma			Eyes surgery		
Retinopathy (damage to the retina)			Prosthetic eye		
	RES	SPIRAT	- ORY		
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			Tuberculosis		
Upper Respiratory Infection (URI)					
Cardiovasc	ULAR	(Cent	RAL / PERIPHERAL)		
Congestive Heart Failure			Murmur		
Coronary Artery Disease (CAD)			Myocardial Infarction (Heart attack)		
Deep Vein Thrombosis (clot in the vein)			Peripheral Vascular Disease		
Hyperlipidemia (High cholesterol)			Vasculitis		
Hypertension (High blood pressure)					
Rheumatic Fever			Venous insufficiency		
GA	ASTROI	NTEST	INAL (GI)		
Cirrhosis of the Liver			Special Diet		
Crohn's Disease			Colostomy		
Gastro Esophageal Reflux (GERD)			lleostomy		
Hepatitis (liver infection)			Ulcerative Colitis		
			1		



New Patient Medical History

PATIENT:

PAST MEDICAL HISTORY CONTINUED

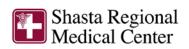
CONSTITUTIONAL (GENERAL HEALTH)						
	Yes	No		Yes	No	
GENITOURINARY (GU)						
Benign Prostate Hyperplasia (enlarged prostate)			Miscarriage			
Dialysis			Prostate Cancer			
End Stage Renal Disease			Sexually Transmitted Disease			
Kidney Disease						
	EN	DOCRI	NE			
Gestational Diabetes (with pregnancy)			Type 1 Diabetes (juvenile onset)			
Thyroid Disease			Type 2 Diabetes (adult onset)			
	Muscu	JLOSKI	ELETAL			
Arthritis			Osteoarthritis			
Gout			Osteomyelitis (bone infection)			
Hip Fracture			Other Fracture			
Osteoporosis						
INTEGUME	NTARY	(Haif	R / SKIN / NAILS)			
Burn			Onchomycosis (nail fungal infection)			
Malignancy (skin cancer)			Scleroderma			
	NEU	ROLOG	BICAL			
Amyotrophic Lateral Sclerosis (ALS)			Multiple Sclerosis			
CNS Trauma Injury			Stroke			
Epilepsy			Transient Ischemic Attack (TIA / mini-stroke)			
Head Injury / LOC						
	Ps	CHIAT	RIC			
Alzheimer's			Depression			
Dementia (loss of mental skills)						
HEM	IATOLC	GIC / I	LYMPHATIC			
Anemia (low blood count)			Lymphedema			
Anticoagulant Therapy			Sickle Cell Anemia			
ALL	ERGIC	/ Імм	UNOLOGIC			
AIDS / HIV			Reynaud's Disease			
Lupus			Rheumatoid Arthritis			
Pyoderma Gangrenosum						



PAST SURGICAL HISTORY (PLEASE PROVIDE PROCEDURES AND DATES AS BEST AS YOU CAN.)

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
Smokeless Tobacco: Dever Rarely Moderate Daily
Nicotine Gum: Y N Electronic cigarettes: Y N
Marital Status 🗆 Single 🗆 Married 🗆 Separated 🗆 Divorced 🗆 Widowed 🗆 Other:
Occupation:
Retired (from):
Veteran: Y N
Children Do Yes IF Yes, HOW MANY:
Caffeine Use: □ Never □ Previously □ Currently Type / Frequency:
Alcohol Use: □ Never □ Rarely □ Moderate □ Daily
Illicit Drug Use: Dever Deviously Currently Type / Frequency:
Cultural, Religious or Language Concerns that may affect your care:
Financial Concerns:
Do family and friends provide help when needed? 🛛 No 🖓 Yes
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 reside in an Assisted Living: Do NO De Yes Long Term Care Facility: Do NO De Yes SNF: Do NO De Yes
Who do you live with?
Do you need assistance with transfers or repositioning? Y N, If yes, explain:
Do you feel safe at home? Y N
Any concerns about Abuse or Neglect: NO VES CONCERNS:
Do you have any feelings of wanting to harm yourself or others? \Box No \Box Yes CONCERNS:
PATIENT SIGNATURE:
have reviewed the New Patient Medical History with the patient / caregiver as part of the Initial Nursing Assessment.
NURSE SIGNATURE: DATE: TIME: