

Date _____

▪ GENERAL INFORMATION

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____

Emergency Contact Information

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

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/Nursing Home _____ Phone _____

Pharmacy _____ Phone _____

Have you ever been a patient at Baylor Medical Center? Yes No

▪ WOUND HISTORY

Wound location: _____

When did you first notice the wound? _____

How did your wound start? _____

Has it ever healed and then re-opened? Yes No

How have you been treating your wound until now? _____

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

PATIENT LABEL

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

Who ordered _____

Have you had any other problems associated with your wound? (Please check)

Infection Swelling Other: _____

MEDICAL HISTORY Please check Yes or No for each item

	PATIENT		MANAGING PHYSICIAN	FAMILY		EXPLAIN (Who, Age)
	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you have diabetes: Do you take: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled How long have you had diabetes? _____ Do you test your blood sugar every day? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many times /day ____ What are your blood sugar testing results? Breakfast_____ Lunch_____ Dinner_____ Bedtime_____
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis/Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Convulsion/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

PATIENT LABEL

IMMUNIZATION	DATE RECEIVED
Tetanus Toxoid	

Pediatric patients under age 14 only

IMMUNIZATION	DATE RECEIVED

SOCIAL HISTORY *Please check one for each item)*

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Previously, but quit _____ years ago Current packs per day _____

Alcohol Use: Never Rarely Moderate Daily

Drug Use: Never Type/Frequency _____

Caffeine Use: Never Type/Frequency _____

SYSTEM REVIEW *Please check Yes or No for each item*

GENERAL SYMPTOMS

Good general health lately Yes No

Fatigue Yes No

Height _____ Weight: _____

EYES

Glaucoma Yes No

Cataracts Yes No

EARS/NOSE/MOUTH/THROAT

Chronic sinus problems or rhinitis Yes No

Sore throat or mouth sores Yes No

Swollen glands in neck Yes No

GASTROINTESTINAL

Frequent diarrhea Yes No

Constipation Yes No

Blood in stool Yes No

INTEGUMENTARY (Skin)

Bleeding or bruising tendency Yes No

Change in mole Yes No

CARDIOVASCULAR

Chest Pain Yes No

Pacemaker: Yes No

If yes, Manufacturer _____

RESPIRATORY

Chronic or frequent coughs Yes No

Spitting up blood Yes No

Shortness of breath/Sleep apnea Yes No

Asthma/Emphysema/TB Yes No

PSYCHIATRIC

Depression Yes No

Claustrophobia Yes No

ENDOCRINE/HEPATIC

Thyroid disease Yes No

Excessive thirst/urination Yes No

Heat/cold intolerance Yes No

Hepatitis Yes No

PATIENT LABEL

MUSCULOSKELETAL

- Joint pain Yes No
- Joint stiffness Yes No
- Weakness of muscles or joints Yes No
- Back Pain Yes No
- Osteoarthritis Yes No

NEUROLOGICAL

- Frequent /recurring headaches Yes No
- Light headed or dizzy Yes No

Staff Only: Reviewed by Staff (See Medical Summary)

Staff Only: ABNORMALITIES ADDRESSED BY RN

HEMATOLOGIC/LYMPHATIC

- Anemia Yes No
- Human Immunodeficiency Virus Yes No

GENITOURINARY

- Frequent urination Yes No
- Blood in urine Yes No
- Incontinence/dribbling Yes No
- Kidney failure/ Dialysis Yes No
- Kidney transplant Yes No

CURRENT HEALTH STATUS (Please check one for each item)

- Energy Level Good Fair Poor
- Physical Function Good Fair Poor
- Social Functioning Good Fair Poor
- Mental Health Good Fair Poor
- Health Perception Good Fair Poor

NUTRITION PROFILE Please check Yes or No for each item

- Difficulty chewing or swallowing? Yes No
- Do you need assistance with eating? Yes No
- Have you had a large weight loss? Yes No
- Have you had a large weight gain?
If yes, _____pounds in _____months. Reason, if known _____ Yes No
- Special diet? Yes No
- Food allergies? Yes No
- Are you involved in weight loss program? Yes No

PATIENT LABEL

Weight Loss Medications: _____

How many meals do you eat each day? _____

Appetite: Good Fair Poor (Please check one)

Do you take nutritional supplements? Yes No

How much water do you drink each day? _____ 8 ounce glasses

Do you exercise regularly? Yes No

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

- Drive Automobile Completely Able Need Assistance Not Able
- Take Medications Completely Able Need Assistance Not Able
- Use telephone Completely Able Need Assistance Not Able
- Care for Appearance Completely Able Needs Assistance Not Able
- Use Toilet Completely Able Needs Assistance Not Able
- Bath/Shower Completely Able Needs Assistance Not Able
- Dress Self Completely Able Needs Assistance Not Able
- Feed Self Completely Able Needs Assistance Not Able
- Walk Completely Able Needs Assistance Not Able
- Get in/out bed Completely Able Needs Assistance Not Able
- Housework Completely Able Needs Assistance Not Able
- Prepare Meals Completely Able Needs Assistance Not Able
- Handle Money Completely Able Needs Assistance Not Able
- Shop for Self Completely Able Needs Assistance Not Able

MEDICARE (Only fill out if currently receiving Medicare)

Have you ever received a kidney transplant? No Yes If yes, date Received _____

Do you participate in a Dialysis Program? No Yes If yes, date Received _____

Do you participate in a Black Lung program? No Yes

Are services covered under a government program, such as a research grant? Yes No

Are you entitled to any Veteran's Administration (VA) benefits? Yes No

Patient Signature _____ Date _____
(Or Legal Guardian/Power of Attorney)

Nurse Signature _____ Date _____

PATIENT LABEL



WOUND CARE CENTER PATIENT ATTENDANCE REQUIREMENTS

Healing of chronic wounds requires a true commitment to treatment. Time-to-healing varies from patient to patient, but can take many weeks. You must be willing to commit to this entire time period for the treatment plan to be effective.

Compliance with physician orders and wound care instructions is essential to obtain maximum healing benefits. Patients must be involved in the design of the treatment plan and must agree with planned frequency and duration of wound care services.

Generally, you will be expected to come to the Wound Center for appointments with your Wound Care Physician every week. You should make all necessary arrangements to come in every week unless otherwise instructed by your Wound Care Physician.

Patients who do not comply with Wound Center appointments will be discharged. Patients will be considered non-compliant if any of the following occurs:

1. Two (2) “no-show/no-call” missed appointments
2. Two (2) appointment cancellations without 24 hour notice
3. Four (4) cancellations in total.

Patients who are more than ten (10) minutes late for their scheduled appointment time may need to be rescheduled. Day and time of rescheduled appointments will be dependent upon available openings. We ask you be on time for all appointments to avoid interfering with other patients’ treatment.

I have read these requirements and have had any of my questions regarding these requirements answered.

I hereby commit myself to following these requirements and my Baylor Wound Center treatment plan.

Patient/Designee Signature

Date