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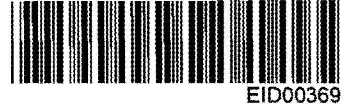
Medical Center
at Carrollton




# 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*



Patient Name: __________

Date: __________

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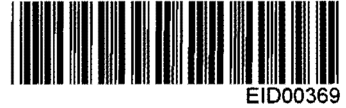
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**SEVERITY:** CIRCLE THE NUMBERS THAT BEST DESCRIBE YOUR CURRENT LEVEL OF PAIN

*Tell Us* If You Have Pain

| | |
|---|---|
| 10 9 | Worst Possible Pain |
| 8 7 | Very Severe Pain |
| 6 5 | Severe Pain |
| 4 3 | Moderate Pain |
| 2 1 | Mild Pain |
| 0 | No Pain |

**ALLERGIES:** *(LIST ALL KNOWN ALLERGIES AND REACTIONS)*

☐ NO KNOWN ALLERGIES ☐ LATEX / RUBBER ☐ TAPE ☐ IODINE

☐ FOOD (LIST): ______________________________

☐ MEDICATIONS (LIST): ______________________________

☐ OTHER: (LIST): ______________________________

**ADVANCED DIRECTIVES & INSTRUCTIONS:** *(CHECK ALL THAT APPLY)*

☐ I HAVE AN ADVANCE DIRECTIVE ☐ I HAVE A LIVING WILL

☐ ADVANCE DIRECTIVE MATERIALS WERE PROVIDED TO ME

☐ 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

## REVIEW OF SYSTEMS / PAST MEDICAL & SURGICAL HISTORY

| **CONSTITUTIONAL (GENERAL HEALTH )** | | | |
|---|---|---|---|
| **COMPLAINTS & SYMPTOMS** | **YES** | **NO** | **COMMENTS** |
| Active | | | |
| Fatigue | | | |
| Fever | | | |
| Loss of Appetite | | | |
| Marked Weight Change | | | |
| Sedentary (low activity level) | | | |
| Night Sweats | | | |
| **MEDICAL HISTORY** | **YES** | **NO** | **COMMENTS** |
| Influenza (Flu) Vaccine Current | | | |
| Pneumonia Vaccine Current | | | |
| Tetanus Vaccine Current | | | |
| Sleep Apnea | | | |
| **ALLERGIC / IMMUNOLOGIC** | | | |
| **COMPLAINTS & SYMPTOMS** | **YES** | **NO** | **COMMENTS** |
| Rhinitis (inflamed nasal passage) | | | |
| Hay Fever | | | |
| **MEDICAL HISTORY** | **YES** | **NO** | **COMMENTS** |
| AIDS | | | |
| Lupus | | | |
| Pyoderma Gangrenosum | | | |
| Reynaud's Disease | | | |
| Rheumatoid Arthritis | | | |
| **CARDIOVASCULAR (CENTRAL / PERIPHERAL)** | | | |
| **COMPLAINTS & SYMPTOMS** | **YES** | **NO** | **COMMENTS** |
| Dyspnea on exertion (shortness of breath with activity) | | | |
| Edema (swelling) | | | |
| Intermittent Claudication (pain on exertion, i.e. walking to mailbox) | | | |



Patient Name: ______________________________

Date: ______________________________

| Orthopnea (shortness of breath when lying down) | | | |
|---|---|---|---|
| Palpitations | | | |
| **Medical History** | **Yes** | **No** | **Comments** |
| Congestive Heart Failure | | | |
| Coronary Artery Disease (CAD) | | | |
| Deep Vein Thrombosis (clot in the vein) | | | |
| Hyperlipidemia (High cholesterol) | | | |
| Hypertension (High blood pressure) | | | |
| Murmur | | | |
| Myocardial Infarction (Heart attack) | | | |
| 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 (SEPS) | | | |
| Valve Replacement | | | |
| Vein Stripping | | | |
| **Ear / Nose / Mouth / Throat** | | | |
| **Complaints & Symptoms** | **Yes** | **No** | **Comments** |
| Hearing Loss / Aid | | | |
| Otalgia (ear ache) | | | |
| Dental Problems | | | |
| Painful or Swollen Lymph Nodes | | | |
| **Medical History** | **Yes** | **No** | **Comments** |
| Barotrauma (damage to ear drum) | | | |
| Sinusitis | | | |
| Tinnitus (ringing in ears) | | | |
| **Surgical History** | **Yes** | **No** | **Comments** |
| Myringotomy (incision in eardrum) | | | |
| Tube Placement (in ear) | | | |
| **Eyes** | | | |
| **Complaints & Symptoms** | **Yes** | **No** | **Comments** |
| Blurred Vision | | | |
| Dry Eyes | | | |
| Vision Changes | | | |
| Glasses / Contacts | | | |
| **Medical History** | **Yes** | **No** | **Comments** |
| Cataracts | | | |
| Glaucoma | | | |
| Retinopathy (damage to the retina) | | | |
| **Surgical History** | **Yes** | **No** | **Comments** |
| Other | | | |
| **Endocrine** | | | |
| **Complaints & Symptoms** | **Yes** | **No** | **Comments** |
| Cold Intolerance | | | |



Patient Name: ______________________

Date: ______________________

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



Patient Name: ______________________

Date: ______________________

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



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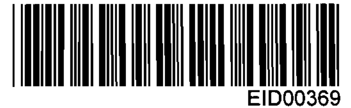


| | | | |
|---|---|---|---|
| Stroke | | | |
| Transient Ischemic Attack (TIA) | | | |
| **PSYCHIATRIC** | | | |
| **COMPLAINTS & SYMPTOMS** | **YES** | **NO** | **COMMENTS** |
| Anxiety | | | |
| Claustrophobia | | | |
| Insomnia | | | |
| Nervousness / Tension | | | |
| Memory Loss | | | |
| **MEDICAL 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 | | | |



Patient Name: ______________________________

Date: ______________________________

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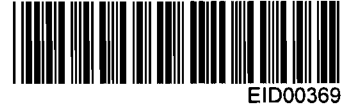
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**Social History**

| | | | | | | |
|---|---|---|---|---|---|---|
| Substance Abuse | ☐ No | ☐ Yes | Describe: | | | |
| Alcohol Use: | ☐ Never | ☐ Rarely | ☐ Moderate | ☐ Daily | | |
| Tobacco Use: | ☐ Never | ☐ Former | ☐ Less than 1 Pack Per Day | ☐ Greater than 1 Pack Per Day | | |
| Smokeless Tobacco Use: | ☐ 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: | | | | | | |
| Support Systems Lacking: | | | | | | |
| Transport Concerns: | | | | | | |
| Unable to Care for Self: | ☐ No | ☐ Yes | Describe: | | | |

**MEDICATIONS - - Write on Back if more room needed**

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

| 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:** __________



Patient Name: ______________________

Date: ______________________