

Height:	Weight:	Date of Birth:
WOUND INFORMATION:		
Where is your wound located?		
How long have you had your wound?		
How did your wound(s) start?		
<input type="checkbox"/> Injury: Describe	<input type="checkbox"/> Surgical Procedure: Describe	
<input type="checkbox"/> Appeared Gradually	<input type="checkbox"/> Other:	
What treatments have been used on your wound?		
<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Hyperbaric Oxygen	
<input type="checkbox"/> Total Contact Casting	<input type="checkbox"/> Soaks	
<input type="checkbox"/> Saline Dressing	<input type="checkbox"/> Compression wrap/Stockings	
<input type="checkbox"/> Topical Gel/Ointment	<input type="checkbox"/> Other:	
Has your wound ever completely healed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your goal for seeking treatment here?		

Doctor who sent you to Center:	Your regular PCP (Primary Care Physician)
Name:	Name:
Type of Doctor:	Type of Doctor:
Phone:	Phone:
Fax:	Fax:

Social History	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Language spoken at home? English, other _____ Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoking: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, How long? _____ Years How much? _____ Packs per day If quit when? _____	
Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Amount per Day: _____ Type: _____	
Recreational Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer _____	
Surgeries	
Date of Procedure	Procedure

Recent Tests or X-rays done before coming to the Wound Center? Yes No

If yes, type of test and when it was done: _____

Immunization: When was your last tetanus shot? ___ Have you received a Flu Shot? Yes, if yes, when? ___
Have you received a Pneumonia shot? Yes, if yes, when? ___ No, for flu or pneumonia, refer to PCP

Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had diabetes?	How Long?
Do you test your blood sugar?	Frequency?
If yes, how often?	Days of the Week:
What do your blood sugars usually run?	Shunt Location?
	Shunt Type?

History of Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Type
Received Radiation <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Where?
Received Chemotherapy <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Where?



R N 4 1 6 5

Patient History Form-RWHC

FR-1551-RWHC 6/2007



Mary Washington Hospital
1001 Sam Perry Boulevard • Fredericksburg, VA 22401

PATIENT IDENTIFICATION
1 1/4" X 3"

PAST /CURRENT MEDICAL HISTORY

- Check **SELF** for those that you have experienced in your life or have right now and explain
- Check **FH** (Family History), *if it applies to immediate family member (siblings, parents, grandparents)*

SELF	FH	Cardiac/Vascular History	SELF	FH	Pulmonary History
		* Congestive Heart Failure			* Smoking
		* Coronary Artery Disease			* COPD (Chronic Obstructive Pulmonary Disease)
		* Peripheral Vascular Disease			Emphysema
		Chest pain/Palpitations			Shortness of Breath
		High Blood Pressure			Asthma
		Heart Attack			Collapsed Lung
		Problem Legs/Feet			Cough/Wheezing
		Poor Circulation			Tuberculosis
		Pain in Legs			Recent Lung/Virus Infection
		Blood clots			Oxygen use
		Pacemaker			

SELF	FH	Gastrointestinal History	SELF	FH	Neuromuscular/Orthopedic History
		* End stage renal			Broken bones
		* Incontinence(bladder/bowel difficulty)			Leg or Foot Deformity
		Trouble swallowing			Weakness
		Reflux disease			
		Nausea/Vomiting/Diarrhea			
		Inflammatory bowel			
		Celiac Disease			

SELF	FH	Neurological History	SELF	FH	Prosthetics
		Paralysis			Implants:
		Tremors			Eye
		Seizure			Breast
		Stroke			Arm Leg
		Numbness (location)			Knee Joint Hip Joint
		Head/Brain Trauma			Dentures, type
					Other implantable devices?

SELF	FH	Other Conditions	SELF	FH	Other Conditions
		*Diabetes			* Malnutrition
		History of infections, bone, skin, other			Low Blood Count
		Immune Deficiency			Anxiety/Panic/Claustrophobia
		Lupus			Problems with ears
		Scleroderma			Eye problems
		Cellulitis			Cataract
		Thyroid Problems			Burns
		Jaundice /Hepatitis			Sickle Cell Anemia

SIGNATURE OF PERSON COMPLETING FORM: _____ Date _____

Reviewed by RN Signature _____

Date _____ Time _____



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