

Outpatient Wound Care Intake Form

Name: _____ Phone: _____

Primary Doctor: _____ Insurance type: _____

Primary language spoken: _____ Do you need an interpreter? Yes No

Are you currently receiving Home Health for any reason? Yes No

Current Symptoms/Chief Complaint: _____

When did your symptoms begin? _____

Causes: Unknown reason Injury Surgery

If injury or surgery, please describe: _____

Are the symptoms getting: Better Worse The same

Any history with this problem (if yes, please describe)? Yes No

What was the previous treatment (check all that apply): Surgery Compression

Skin substitutes Pulsed Lavage Dressing changes only

Other: _____

Did it work? Yes No

What are your goals? _____

Previous tests or Surgeries related to this problem (check all that apply):

- | | | | |
|---|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Vascular Doppler | <input type="checkbox"/> MRI | <input type="checkbox"/> X ray | <input type="checkbox"/> CAT scan |
| <input type="checkbox"/> Vein Ablation | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Cultures | <input type="checkbox"/> Skin graft |
| <input type="checkbox"/> Arterial bypass | <input type="checkbox"/> Amputation | <input type="checkbox"/> Recent Labs | <input type="checkbox"/> Debridement |
| <input type="checkbox"/> Muscle flap | Other: | | |

Past Medical History:

What allergies do you have? (Check all that apply).

- None Iodine sulfa drugs Penicillin Tape adhesive
 Latex Other: _____

Have you ever been diagnosed with any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Implanted Defibrillator | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision problems | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Problems with circulation | <input type="checkbox"/> Gangrene | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Dehydration |
| <input type="checkbox"/> Rheumaty Arthritis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Problems controlling urine | <input type="checkbox"/> Problems controlling bowel | |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Quadraplegia | <input type="checkbox"/> Paraplegia |
| <input type="checkbox"/> Polio or post polio | <input type="checkbox"/> Decreased Sensation | <input type="checkbox"/> Myelomeningocele |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> HIV | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Thyroid disorder |

Cancer: Yes No

Type: _____

Have you ever had radiation or chemotherapy? _____

Diabetes: Yes No

If yes, what were your blood sugar levels this morning? _____

If yes, what was your most recent A1C? _____

Kidney disease: Yes No

If yes, are you currently on dialysis? Yes or No

Have you noticed any unexplained weight gain or loss due to swelling? Yes No

Do you smoke cigarettes, cigars or pipe? Yes No # of Packs per Day: _____

Please list any additional past medical history:

Medication:

Please check any of the medicines you are taking now:

Lasix/Waterpill Steroids Chemotherapy

Coumadin/aspirin/blood thinners Antibiotics

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

| Medicines | Dose | How often taken |
|------------------|-------------|------------------------|
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Functional Status:

Do you need any help to walk or transfer into a chair? Yes No

Do you use any of the following to help you with mobility (check all that applies):

Cane Walker Wheelchair/Scooter Other _____

Who changes your dressings? Self Spouse Caregiver Other: _____

How often are your dressings changed? Once a day Twice a day

Three or more per day Every other day Once a week Other: _____

What types of dressing do you use (include topical medications and ointments)?

Are you currently working? Yes No What type of work do you

do?: _____

Pain Profile:

Do you have pain now? Yes No

Where is your pain located? _____

What is your pain rating from 0 to 10 (0=no pain, 10=worst pain ever)

Now=_____ Worst=_____ Best=_____

How would you describe your pain? (Check all that apply)

- | | | | | |
|------------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Chronic | <input type="checkbox"/> Continuous | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Pressure | <input type="checkbox"/> Phantom |
| <input type="checkbox"/> Sudden | <input type="checkbox"/> Aching | <input type="checkbox"/> Sharp | <input type="checkbox"/> Spasm | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Dull | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Tightness | Other: _____ | | | |

What makes your pain worse? (Check all that apply)

- | | | | | |
|----------------------------------|-----------------------------------|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Laying down |
| Other: _____ | | | | |

What relieves your pain? (Check all that apply)

- | | | | | |
|---|-----------------------------------|-----------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Resting | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Medications | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Laying Down | |
| <input type="checkbox"/> Changing Positions | Other: _____ | | | |

Victim Abuse:

Is a partner physically, emotionally or mentally abusing you? Yes No

Is it safe for you to go home? Yes No

Are you at risk of being harmed by anyone close to you? Yes No

Would you like any information on community services available to you in regard to the above asked questions? Yes No

Advanced Directives:

Do you have advanced directives such as: a Living Will, a Power of Attorney for Health Care, Five Wishes, or Illinois Department of Public Health Universal DNR Advance Directive? Yes No

Nutrition:

Is your wound non-healing/or has not improved in the past 3 weeks?

Yes No

Have you lost weight over the past few weeks? Yes No

Height: _____ Weight: _____

Can you drink milk? Yes No

Are you on a special diet? Yes No

If yes, please describe: _____

Please check each statement that is true for you:

- I have an illness or condition that has made me change the kind and/or amount of food that I eat
- I eat fewer than 2 meals a day
- I eat less than 3 servings of fruit, vegetables or milk products per day
- I have 3 or more drinks of beer, wine and/or liquor almost everyday
- I have mouth problems or teeth problems which make it difficult for me to eat
- I don't always have enough money to buy food
- I live alone and/or eat alone
- I take medicines which decrease my appetite and/or food intake
- Without trying, I have lost or gained more than 10 pounds
- I am not physically able to cook, shop and/or feed myself

Are there any barriers to your treatment?

Transportation Financial Environmental Social

Please explain: _____

How do you learn best?

Pictures Reading Listening Watching Other: _____

Do you have any specific customs, wishes or religious beliefs that might affect care? _____

