Staple

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

1117744

HILLCREST HEALTHCARE SYSTEM
OUTPATIENT WOUND CARE CLINIC
TULSA, OKLAHOMA 74104

HMC7744 (05/12)

PATIENT HISTORY

GENERAL INFORMATION

NAME:		HOME PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
BIRTHDATE:	AGE:	SEX:	
REFERRING PHYSICIAN NAME:	SPECIALTY:		PHONE:
ADDRESS:	CITY:	STATE:	ZIP:

HAVE YOU EVER BEEN A PATIENT AT ANY HILLCREST HEALTHCARE SYSTEM FACILITY?
(EX. HILLCREST SOUTH, BAILEY MEDICAL CENTER, UTICA PARK CLINIC) ❑ YES ❑ NO

HOW DID YOU LEARN ABOUT HILLCREST WOUND CARE CLINIC? (PLEASE CHECK ALL THAT APPLY)
❑ PHYSICIAN ❑ NURSE ❑ FRIEND/RELATIVE ❑ HOME HEALTH ❑ OTHER:

WOUND HISTORY

WOUND LOCATION:
WHEN DID YOU FIRST NOTICE THE WOUND?
HOW DID YOUR WOUND START?
HAS IT EVER HEALED AND THEN RE-OPENED?
DOES YOUR WOUND PREVENT YOU FROM PERFORMING DAILY ACTIVITIES?
HOW HAVE YOU BEEN TREATING YOUR WOUND UNTIL NOW?
HAVE YOU BEEN TREATED AT ANY OTHER CLINIC FOR YOUR WOUND?
HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH?
❑ NO ❑ YES WHERE?
HAVE YOU HAD ANY TESTS FOR CIRCULATION IN YOUR LEGS?
❑ NO ❑ YES WHERE?
HAVE YOU HAD ANY OTHER PROBLEMS ASSOCIATED WITH YOUR WOUND?
❑ INFECTION ❑ SWELLING ❑ OTHER ❑ NO

MEDICAL HISTORY

	PATIENT		FAMILY		**EXPLAIN** (age, relation)
	YES	**NO**	**YES**	**NO**	
DIABETES					
HYPERTENSION					
CANCER					
STROKE/TIA					
PARALYSIS					
PHLEBITIS/DVT					
COPD/EMPHYSEMA					
HEART TROUBLE					
RHEUMATOID ARTHRITIS					
GOUT					
CONVULSIONS/SEIZURES					
LUPUS					
ULCERATIVE COLITIS					
CROHN'S DISEASE					
SCLERODERMA					

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DIABETES

IF YOU HAVE DIABETES:

DO YOU TAKE (select all that apply): ❑ INSULIN ❑ ORAL MEDS ❑ DIET CONTROLLED

HOW LONG HAVE YOU HAD DIABETES?

DO YOU TEST YOUR BLOOD SUGAR EVERY DAY? ❑ NO ❑ YES if yes, how many times/day?

MEDICATIONS

MEDICATION	DOSAGE	HOW OFTEN

ALLERGIES

PLEASE LIST ALL KNOWN ALLERGIES AND REACTIONS:

CURRENT HEALTH

BODY PAIN	❑ NONE	❑ SOME	❑ SEVERE
ENERGY LEVEL	❑ GOOD	❑ FAIR	❑ POOR
PHYSICAL FUNCTION	❑ GOOD	❑ FAIR	❑ POOR
MENTAL HEALTH	❑ GOOD	❑ FAIR	❑ POOR
HEALTH PERCEPTION	❑ GOOD	❑ FAIR	❑ POOR

ACTIVITIES OF DAILY LIVING

Please check one for each item:	COMPLETELY ABLE	NEED ASSISTANCE	NOT ABLE
Drive automobile	❑	❑	❑
Take medications	❑	❑	❑
Use telephone	❑	❑	❑
Care for appearance	❑	❑	❑
Use toilet	❑	❑	❑
Bathe/shower	❑	❑	❑
Dress self	❑	❑	❑
Feed self	❑	❑	❑
Walk	❑	❑	❑
Get in/out of bed	❑	❑	❑
Housework	❑	❑	❑
Prepare meals	❑	❑	❑
Handle money	❑	❑	❑
Shop for self	❑	❑	❑

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SOCIAL HISTORY

MARITAL STATUS:	❑ SINGLE	❑ MARRIED	❑ SEPARATED	❑ DIVORCED	❑ WIDOWED
TOBACCO USE:	❑ NEVER	❑ PREVIOUSLY, but quit years ago		❑ CURRENT (chew or packs per day):	
ALCOHOL USE:	❑ NEVER	❑ _____ drinks/day	❑ _____drinks/week		
DRUG USE:	❑ NEVER	❑ YES, TYPE/FREQUENCY:			
CAFFEINE USE:	❑ NEVER	❑ YES, TYPE/FREQUENCY:			

NUTRITION PROFILE

	YES	NO
DIFFICULTY CHEWING OR SWALLOWING?	❑	❑
HAVE YOU RECENTLY HAD A LARGE WEIGHT LOSS OR GAIN? (please circle loss or gain)	❑	❑
If yes, pounds in months. Reason, if known:		
DO YOU FOLLOW A SPECIAL DIET?	❑	❑
If yes, please explain:		
DO YOU HAVE ANY FOOD ALLERGIES?	❑	❑
If yes, please explain:		
ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM?	❑	❑
Weight loss meds: How many meals do you eat each day?		
APPETITE: ❑ Good ❑ Fair ❑ Poor		
DO YOU TAKE NUTRITIONAL SUPPLEMENTS?	❑	❑
If yes, please explain:		
HOW MUCH WATER DO YOU DRINK EACH DAY? _____8 ounce glasses		
DO YOU EXERCISE REGULARLY?	❑	❑

SURGICAL HISTORY

PROCEDURE	NAME OF HOSPITAL	DATE

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REVIEW OF SYSTEMS

	YES	NO
GENERAL SYMPTOMS		
Good general health	❑	❑
Fatigue	❑	❑
EYES		
Blurred or double vision	❑	❑
Glaucoma	❑	❑
Wear glasses or contacts	❑	❑
Cataracts	❑	❑
EARS/NOSE/MOUTH/THROAT		
Hearing loss or ringing	❑	❑
Earaches	❑	❑
Chronic sinus problems or rhinitis	❑	❑
Nose bleeds	❑	❑
Sore throat or mouth sores	❑	❑
Swollen glands in neck	❑	❑
GASTROINTESTINAL		
Frequent heartburn	❑	❑
Frequent diarrhea	❑	❑
Constipation	❑	❑
Blood in stool	❑	❑
INTEGUMENTARY (skin)		
Rash or itching	❑	❑
Bleeding or bruising tendency	❑	❑
Change in moles	❑	❑
MUSCULOSKELETAL		
Joint pain	❑	❑
Joint stiffness	❑	❑
Swelling in lower extremities	❑	❑
Weakness of muscles or joints	❑	❑
Back pain	❑	❑
Osteoarthritis	❑	❑
NEUROLOGICAL		
Frequent/recurring headaches	❑	❑
Light headed or dizzy	❑	❑

	YES	NO
CARDIOVASCULAR		
Chest pain	❑	❑
Varicose veins	❑	❑
Swelling of feet, ankles or hands	❑	❑
Pacemaker	❑	❑
RESPIRATORY	❑	❑
Chronic or frequent coughs	❑	❑
Spitting up blood	❑	❑
Shortness of breath	❑	❑
Asthma or wheezing	❑	❑
Emphysema	❑	❑
Tuberculosis	❑	❑
Sleep apnea	❑	❑
PSYCHIATRIC		
Memory loss or confusion	❑	❑
Depression	❑	❑
Claustrophobia	❑	❑
ENDOCRINE/HEPATIC		
Glandular or hormone problems	❑	❑
Thyroid disease	❑	❑
Excessive thirst or urination	❑	❑
Heat or cold intolerance	❑	❑
Hepatitis	❑	❑
GENITOURINARY		
Frequent urination	❑	❑
Blood in urine	❑	❑
Incontinence/dribbling	❑	❑
Female-irregular periods	❑	❑
Kidney failure	❑	❑
Dialysis	❑	❑
Kidney transplant	❑	❑

	Date	Time
Patient Signature	/ /	
Legal Guardian/Power of Attorney	/ /	
RN Signature	/ /	
Physician Signature	/ /	