

GENERAL INFORMATION	NAME:		HOME PHONE:		
	ADDRESS:	CITY:	STATE:	ZIP:	
	BIRTHDATE:	AGE:	SEX:		
	PHYSICIAN WHO REFERRED YOU TO THE WOUND HEALING CENTER:				
	NAME:	SPECIALTY:		PHONE:	
	ADDRESS:	CITY:	STATE:	ZIP:	
	PRIMARY CARE PHYSICIAN:				
	NAME:	SPECIALTY:		PHONE:	
	ADDRESS:	CITY:	STATE:	ZIP:	
	HOME HEALTH CARE/NURSING HOME:			PHARMACY:	
	HAVE YOU EVER BEEN A PATIENT AT THE OHIO STATE UNIVERSITY HEALTH SYSTEM: (ex. University Hospital East, University Hospital, James Care, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO				
	HOW DID YOU LEARN ABOUT THE WOUND HEALING CENTER? (Please check all that apply): <input type="checkbox"/> Television <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Friend/Relative <input type="checkbox"/> 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 HAD ANY LAB WORK DONE IN THE PAST MONTH? <input type="checkbox"/> YES <input type="checkbox"/> NO WHO ORDERED?					
HAVE YOU HAD ANY TESTS FOR CIRCULATION ON YOUR LEGS? <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE DONE?					
WHO ORDERED?					
HAVE YOU HAD ANY OTHER PROBLEMS ASSOCIATED WITH YOUR WOUND? (please check): <input type="checkbox"/> Infection <input type="checkbox"/> Swelling <input type="checkbox"/> Other: _____					
THE OHIO STATE UNIVERSITY HEALTH SYSTEM COMPREHENSIVE WOUND CENTER PATIENT HISTORY					

		PATIENT		FAMILY		EXPLAIN (who, age)
		YES	NO	YES	NO	
MEDICAL HISTORY	DIABETES					
	HYPERTENSION					
	CANCER					
	STROKE					
	PARALYSIS					
	PHLEBITIS/DEEP VEIN THROMBOSIS					
	MISCARRIAGE					
	HEART TROUBLE					
	RHEUMATOID ARTHRITIS					
	GOUT					
	CONVULSIONS/SEIZURES					
	LUPUS					
	ULCERATIVE COLITIS					
	CROHN'S DISEASE					
SCLERODERMA						
DIABETES	If you have diabetes:					
	Do you take (please check all that apply): <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"/> YES <input type="checkbox"/> NO If yes, how many times/day?					
	What are your blood sugar testing results? Breakfast _____ Lunch _____ Dinner _____ Bedtime _____					
MEDICATIONS	Please list all medicines you are currently taking. Include over the counter, herbal supplements and vitamins					
	MEDICATION	DOSAGE			HOW OFTEN	
ALLERGIES	Please list all known allergies and reactions:					

HOSPITALIZATION/SURGICAL HISTORY	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION	DATE

NUTRITION PROFILE		YES	NO
	DIFFICULTY CHEWING OR SWALLOWING?	<input type="checkbox"/>	<input type="checkbox"/>
	DO YOU NEED ASSISTANCE WITH EATING?	<input type="checkbox"/>	<input type="checkbox"/>
	HAVE YOU HAD A LARGE WEIGHT LOSS OR GAIN? (please circle loss or gain)	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, pounds in months. Reason, if known		
	DO YOU FOLLOW A SPECIAL DIET?	<input type="checkbox"/>	<input type="checkbox"/>
	Please explain:		
	DO YOU HAVE ANY FOOD ALLERGIES?	<input type="checkbox"/>	<input type="checkbox"/>
	Please explain:		
	ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM?	<input type="checkbox"/>	<input type="checkbox"/>
	Weight Loss Medications:	How Many Meals Do You Eat Each Day?	
	APPETITE: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
	DO YOU TAKE NUTRITIONAL SUPPLEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
	Please explain:		
HOW MUCH WATER DO YOU DRINK EACH DAY? _____ 8 ounce glasses			
DO YOU EXERCISE REGULARLY?	<input type="checkbox"/>	<input type="checkbox"/>	

SOCIAL HISTORY	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
	TOBACCO USE: <input type="checkbox"/> NEVER <input type="checkbox"/> PREVIOUSLY, but quit years ago <input type="checkbox"/> CURRENT, packs per day:
	ALCOHOL USE: <input type="checkbox"/> NEVER <input type="checkbox"/> RARELY <input type="checkbox"/> MODERATE <input type="checkbox"/> DAILY
	DRUG USE: <input type="checkbox"/> NEVER <input type="checkbox"/> TYPE/FREQUENCY:
	CAFFEINE USE: <input type="checkbox"/> NEVER <input type="checkbox"/> TYPE/FREQUENCY:

THE OHIO STATE UNIVERSITY HEALTH SYSTEM COMPREHENSIVE WOUND CENTER PATIENT HISTORY	
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	YES	NO	YES	NO
	GENERAL SYMPTOMS			CARDIOVASCULAR
Good General Health	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/> <input type="checkbox"/>
Height: Weight:			Swelling of feet, ankles or hands	<input type="checkbox"/> <input type="checkbox"/>
EYES			Pacemaker: (manufacturer) _____	<input type="checkbox"/> <input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent coughs	<input type="checkbox"/> <input type="checkbox"/>
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/> <input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/> <input type="checkbox"/>
EARS/NOSE/MOUTH/THROAT			Asthma or wheezing	<input type="checkbox"/> <input type="checkbox"/>
Hearing loss or ringing	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Chronic sinus problems or rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/> <input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	
Sore throat or mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss or confusion	<input type="checkbox"/> <input type="checkbox"/>
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>
GASTROINTESTINAL			Claustrophobia	<input type="checkbox"/> <input type="checkbox"/>
Frequent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE/HEPATIC	
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Glandular or hormone problems	<input type="checkbox"/> <input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/> <input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination	<input type="checkbox"/> <input type="checkbox"/>
INTEGUMENTARY (skin)			Heat or cold intolerance	<input type="checkbox"/> <input type="checkbox"/>
Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>
Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC	
Change in mole	<input type="checkbox"/>	<input type="checkbox"/>	Slow to heal after cuts	<input type="checkbox"/> <input type="checkbox"/>
MUSCULOSKELTAL			Anemia	<input type="checkbox"/> <input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Lymphedema	<input type="checkbox"/> <input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Human immunodeficiency virus	<input type="checkbox"/> <input type="checkbox"/>
Swelling in lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	
Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/> <input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence/dribbling	<input type="checkbox"/> <input type="checkbox"/>
NEUROLOGICAL			Female- irregular periods	<input type="checkbox"/> <input type="checkbox"/>
Frequent/recurring headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney failure	<input type="checkbox"/> <input type="checkbox"/>
Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/> <input type="checkbox"/>
			Kidney transplant	<input type="checkbox"/> <input type="checkbox"/>
CURRENT HEALTH	BODY PAIN	<input type="checkbox"/> NONE	<input type="checkbox"/> SOME	<input type="checkbox"/> SEVERE
	ENERGY LEVEL	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
	PHYSICAL FUNCTION	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
	SOCIAL FUNCTIONING	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
	MENTAL HEALTH	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
	HEALTH PERCEPTION	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
ACTIVITIES OF DAILY LIVING	Please check one for each item:	COMPLETELY ABLE	NEED ASSISTANCE	NOT ABLE
	Drive Automobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Take medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Use telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Care for appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Use toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bath/shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Feed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Get in/out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prepare meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Handle money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shop for self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICARE RECIPIENTS ONLY:					
MEDICARE	HAVE YOU EVER RECEIVED A KIDNEY TRANSPLANT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE RECEIVED:	
	DO YOU PARTICIPATE IN A DIALYSIS PROGRAM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE RECEIVED:	
	DO YOU PARTICIPATE IN A BLACK LUNG PROGRAM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	Are Services Covered Under A Government Program, Such As A Research Grant?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Are you entitled to any verteran's administration (VA) benefits?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
IMMUNIZATION RECORD	IMMUNIZATION (10 yrs old & younger only)		DATE RECEIVED		
	Ex. Tetanus Toxoid				
PATIENT SIGNATURE:			DATE:		
(Or Legal Guardian/ Power Of Attorney)					
NURSING SIGNATURE:			DATE:		