Northwestern Medicine®

PATIENT HISTORY

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

GENERAL INFORMATION

Name _____ Home Phone _____
Address _____ Mobile Phone _____
City _____ State _____ Zip code _____ Email _____
Race ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Pacific Islander ☐ Other ☐ White
Ethnicity ☐ Hispanic ☐ Non-Hispanic
Language ☐ English ☐ Spanish ☐ Other: _____
Ambulatory Status ☐ Independent ☐ Assistive Device ☐ Stretcher ☐ Special Equipment Needed
Communication Preference ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Mail
How Heard ☐ Physician ☐ Self-referral ☐ Former Patient ☐ Advertising ☐ Extended Care Facility
☐ Friend/Family ☐ Home Health ☐ Hospital
Do you live alone? ☐ Yes ☐ No Do you drive? ☐ Yes ☐ No Employed? ☐ Yes ☐ No
Emergency Contact _____ Relationship _____ Phone _____

What provider referred you to the Wound Care Center®?

Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

Who is your primary provider?

Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

Please provide contact information (if applicable):

Home Health Agency _____ Phone _____
Nursing Home/Skilled Facility _____ Phone _____
Pharmacy _____ City _____ Phone _____

WOUND HISTORY

How many open wounds do you have? _____ Location? _____ How long have you had them? _____
How have you been treating your wound(s)? _____
Has your wound ever healed and re-opened? ☐ Yes ☐ No
Have you had any lab work done in the past month? ☐ Yes ☐ No If Yes, Who Ordered? _____
Have you ever had bacteria that resisted antibiotics? ☐ Yes ☐ No If Yes, When? _____
Have you ever had a bone infection? ☐ Yes ☐ No If Yes, When? _____
Have you had any tests for blood flow in your legs? ☐ Yes ☐ No If Yes, When? _____
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

Cataracts (Cloudy vision)	☐ Yes	☐ No	Vasculitis (Inflammation of your blood vessels)	☐ Yes	☐ No
Glaucoma (Eye disease)	☐ Yes	☐ No	Cirrhosis (Liver problems)	☐ Yes	☐ No
Chronic Sinus problems/congestion	☐ Yes	☐ No	Colitis (Bowel problems)	☐ Yes	☐ No
Middle ear problems	☐ Yes	☐ No	Crohn's (Bowel problems)	☐ Yes	☐ No
Anemia (Tired, or low iron)	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No
Hemophilia (Bleeding disorder)	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Human Immunodeficiency Virus (HIV)	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Lymphedema (Swelling in legs or arms)	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No	Type I Diabetes	☐ Yes	☐ No
Asthma (Breathing problem)	☐ Yes	☐ No	Type II Diabetes	☐ Yes	☐ No
Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes	☐ No	End Stage Renal Disease (Kidney disease)	☐ Yes	☐ No
Pneumothorax (Collapsed lung)	☐ Yes	☐ No	Lupus (Problem with your immune system)	☐ Yes	☐ No
Sleep Apnea (Stop breathing when sleeping)	☐ Yes	☐ No	Raynaud's Syndrome	☐ Yes	☐ No

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PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

Tuberculosis (infection in the lungs)	☐ Yes	☐ No	Scleroderma (Skin disorder)	☒ Yes	☐ No
Angina (Chest pain)	☐ Yes	☐ No	History of Burn	☐ Yes	☐ No
Arrhythmia (Skipped heartbeat)	☐ Yes	☐ No	Gout (Pain in big toes)	☐ Yes	☐ No
Atrial Fibrillation (Rapid heart rate)	☐ Yes	☐ No	Osteoarthritis (Pain in bones or joints)	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Rheumatoid Arthritis (Swelling of joints)	☐ Yes	☐ No
Coronary Artery Disease (Heart disease)	☐ Yes	☐ No	Dementia (Memory loss over time)	☐ Yes	☐ No
Deep Vein Thrombosis (Blood clot in leg)	☐ Yes	☐ No	Neuropathy (Numbness in hands or feet)	☐ Yes	☐ No
Hypertension (High blood pressure)	☐ Yes	☐ No	Paraplegia (Can't move arms or legs)	☐ Yes	☐ No
Hypotension (Low blood pressure)	☐ Yes	☐ No	Quadriplegia (Can't move arms and legs)	☐ Yes	☐ No
Myocardial Infarction (Heart attack)	☐ Yes	☐ No	Received Chemotherapy	☐ Yes	☐ No
Peripheral Arterial Disease	☐ Yes	☐ No	Received Radiation	☐ Yes	☐ No
Peripheral Venous Disease	☐ Yes	☐ No	Anorexia/bulimia	☐ Yes	☐ No
Phlebitis (Inflammation of the veins)	☐ Yes	☐ No	Confinement Anxiety (Fear of closed space)	☐ Yes	☐ No

IMMUNIZATIONS

Have you ever received a pneumococcal vaccination? ☐ Yes ☐ No When was your last tetanus shot? _____

HOSPITALIZATION/SURGERY HISTORY (*Please list all)*

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

FAMILY MEDICAL HISTORY *(Please indicate if any of your family members have or had this condition)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hereditary Spherocytosis	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Lung Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If Yes, for how many years? _____ How many packs per day? _____

If quit, when? _____

Marital Status ☐ Separated ☐ Divorced ☐ Married ☐ Single ☐ Widowed

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Type _____

Recreational Drug Use ☐ No History ☐ Prior History ☐ Current History Type _____

Caffeine Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Type _____

Financial Concerns? ☐ Yes ☐ No Food/Clothing/Shelter Needs? ☐ Yes ☐ No

Support System Lacking? ☐ Yes ☐ No Transportation Concerns? ☐ Yes ☐ No

Do you have any of the following?

Advance Directive ☐ Yes* ☐ No Living Will ☐ Yes* ☐ No

Medical Power of Attorney ☐ Yes* ☐ No Do Not Resuscitate ☐ Yes* ☐ No

Do you want information on Advanced Directives? ☐ Yes ☐ No

Staff Use Only:

☐ *Copy Requested Initials: _____

☐ *Copy Provided Initials: _____

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SOCIAL HISTORY (Continued)

Has anyone close to you tried to hurt or harm you recently?	☐ Yes	☐ No	Has anyone forced you do things that you didn't want to do?	☐ Yes	☐ No
Do you feel uncomfortable with anyone in your family?	☐ Yes	☐ No	Do you have any thoughts of harming yourself?	☐ Yes	☐ No

Please rate your ability to perform the following functions:

Task	Completely Able	Need Assistance	Not Able	Task	Completely Able	Need Assistance	Not Able	Task	Completely Able	Need Assistance	Not Able
Drive Automobile	☐	☐	☐	Use Toilet	☐	☐	☐	Prepare Meals	☐	☐	☐
Take Medications	☐	☐	☐	Bath / Shower	☐	☐	☐	Handle Money	☐	☐	☐
Use Telephone	☐	☐	☐	Dress Self	☐	☐	☐	Shop for Self	☐	☐	☐
Care for Appearance	☐	☐	☐	Housework	☐	☐	☐				

Learning preference? ☐ Explanation ☐ Demonstration ☐ Communication Board ☐ Printed Materials ☐ Video

Highest education? ☐ Grade School ☐ High School ☐ College or above

Have you had 2 or more falls in the last 12 months?	☐ Yes	☐ No	Have you had any fall that resulted in injury in the last 12 months?	☐ Yes ☐ No
Do you use an ambulatory aid? If yes, which?	☐ Yes	☐ No	Have you fallen within the last 3 months?	☐ Yes ☐ No

☐ Wheelchair ☐ Crutches ☐ Furniture ☐ Cane ☐ Walker ☐ Other: _____

I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ Yes	☐ No
I eat fewer than two meals per day	☐ Yes	☐ No
I eat few fruits and vegetables, or milk products	☐ Yes	☐ No
I have three or more drinks of beer, liquor or wine almost every day	☐ Yes	☐ No
I have tooth or mouth problems that make it hard for me to eat	☐ Yes	☐ No
I don't always have enough money to buy the food I need	☐ Yes	☐ No
I eat alone most of the time	☐ Yes	☐ No
I take three or more different prescribed or over-the-counter drugs a day	☐ Yes	☐ No
Without wanting to, I have lost or gained 10 pounds in the last six months	☐ Yes	☐ No
I am not always physically able to shop, cook and/or feed myself	☐ Yes	☐ No

Do you have any allergies? _____

Name of Person Completing Form: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____