PRINCETON
WOUND CARE CENTER

PATIENT HISTORY

Date_____

GENERAL INFORMATION

Name_____Home Phone_____

Address_____Cell Phone _____

City_____State____Zip_____

E-mail:_____

DateofBirth_____Age_____Sex _____

Doyoulivealone:□ No □ Yes Do you drive: □ No □ Yes

Emergency Contact Information

Name_____Home Phone_____

Relationship_____Cell Phone_____

Referring Physician

Name_____Specialty_____Phone _____

Address_____City_____State____Zip_____

Primary Physician

Name_____Specialty_____Phone _____

Address_____City_____State____Zip_____

Pharmacy_____Phone_____

Allergies: _____

WOUND HISTORY

Wound location:_____ Has it ever healed and then re-opened? ☐Yes ☐No

When did you first notice the wound? _____

How did your wound start (wounding event)? □ Bite □ Blister □ Bruise □ Bump□ Chemical Burn □ Footwear □ Frostbite □ Gradually Appeared □ Not Known □ Other_____ □ Pimple □ Pressure □ Radiation Burn □ Surgical Wound □Thermal Burn □Trauma

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How have you been treating your wound until now? _____

_____

Have you had any lab work done in the past month? ☐ No ☐ Yes

Have you tested positive for an antibiotic resistant organism (MRSA, VRE)? ☐ No ☐ Yes Date: _____

Have you tested positive for osteomyelitis (bone infection)? ☐ No ☐ Yes Date: _____

Have you had any tests for circulation on your legs? ☐ No ☐ Yes. Where done

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

	Yes	No		Yes	No
Cardiovascular			***Endocrine***		
Angina			Hyperthyroid		
Congestive Heart Failure			Hypothyroid		
Coronary Artery Disease			Diabetes		
Deep Vein Thrombosis			Do you take: ☐Insulin ☐Oral Agents ☐Diet Controlled		
Hypertension					
Hypotension			Doyoutestyourbloodsugareveryday? ☐Yes HowOften___		
Myocardial Infarction					
Peripheral Arterial Disease			What are your usual blood sugar results:		
Peripheral Venous Disease			Breakfast:_____Lunch:_____Dinner:_____Bedtime:		
Stroke			***Eyes***		
Vasculitus			Cataracts		
Gastrointestinal			Diabetic Retinopathy		
Cirrhosis			Glaucoma		
Colitis			***Genitourinary***		
Crohn's Disease			Dialysis		
Hepatitis(Type:___)			End Stage Renal Disease		
Neurological			***Hematologic/Lymphatic***		
Dementia			Anemia		
Epilepsy			Leukocytopenia		
History of Seizures			Lymphedema		
Neuropathy			Sickle Cell Disease		
Paraplegia			HIV		
Quadriplegia			***Immunological***		
Pulmonary			Lupus		
Emphysema			Raynaud's Syndrome		
Pulmonary Embolism			Scleroderma		
Asthma			***Integumentary***		
Chronic Obstructive Pulmonary Disease			History of Burn		
Collapsed Lung/Pneumothorax			***Oncological***		
Use Supplemental Oxygen			Type of Cancer:		
Musculoskeletal			☐Chemo date: ☐Radiation date:		
Gout			***Psychiatric***		
Osteoarthritis			Confinement Anxiety		
Rheumatoid Arthritis			Depression		
Ear/Nose/Mouth/Throat			***Reproductive***		
Chronic Sinus problems/congestion			Miscarriage		
Middle ear problems					
Immunizations: When was your last tetanus shot?			***Any implantable devices?***		

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FAMILY MEDICAL HISTORY					
Pleaseindicatewithacheckmarkif any of your family members have/had this condition.	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Thyroid					

HOSPITALIZATION/SURGERY HISTORY (*Please list all past hospitalizations)*

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

NOTES:

Please bring an UPDATED copy of your MEDICATION LIST

Person Completing Form:

_____**Date/Time:**_____

(Signature/Relationship to Patient)

How did you hear about us?

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WOUND CARE CENTER

Insurance Information

Appointment Time/Date: _____

Patient Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, Zip: _____ Social Security #: _____

Email: _____ Preferred Confidential Method: ☐ E-mail ☐ Primary Phone ☐ Secondary Phone

DOB: ____/____/____ Age: _____ Sex: _____ Race _____ Ethnicity: _____

Primary Language _____

Employer Name: _____ Occupation: _____ Work Phone: _____
Employer Address: _____
Marital Status: M S W D Spouse Name: _____ Work Phone: _____

Is your insurance a PPO or HMO? ☐ No ☐ Yes

INSURANCE	**Primary**	**Secondary**
Name of Company		
Company Address		
Phone Number/Contact		
Policy Number		
Group Name/Number		
Authorization Number:		
Insured/Relationship		
Benefits Verified	Date: Deductible: $	Date: Deductible: $

If Insurance is Medicare: Part B Eligible? ☐ No ☐ Yes

Is patient currently a Long Term Care/Skilled Facility Resident? No Yes Care Center Name: _____
Is patient currently in their 100 day Part A stay? No Yes
If yes, when does it expire? Date: _____
Durable Power of Attorney (if applicable): _____ Phone: _____

Ambulatory Status: ☐ Independent ☐ Assistive Device ☐ Stretcher ☐ Special Equipment to transfer needed