Name _____

New England Wound Care

What is the reason for your visit today? _____

- Where is your wound located? _____
- How long have you had this wound(s)? _____
- How did the wound(s) occur? _____
- Describe any signs or symptoms associated with your wound(s) (pain, drainage, odor, numbness, etc)?

  _____
- Have you had any cultures, x-rays, or tests done for this wound(s)?_____
- Have you had any vascular studies? (ABIs, arterial or venous ultrasound)?

  _____
- Have you taken any antibiotics for this wound(s)? _____
- How have you been dressing your wound(s)? _____
- Do you have a VNA (visiting nurse)? If yes, who?_____
- Has your wound impacted your activities of daily living?_____

Social History:

Smoking:	Y/ N?	How much? What do you smoke?	Quit Y/ N? Date:
Alcohol use:	Y/N?	How often? Type?	
Substance use:	Y/N?	Describe:	
Caffiene:	Y/N?	How much?	
Nutrition:	Appetite: Poor/Fair/Good?	Special diet (diabetic, low salt, etc.)?	

Allergies (reactions):_____
Advance Directive/Healthcare Proxy:_____
Occupation: _____
Emergency Contact (Name/Relation and Number): _____
_____
Do you wear compression?/ Offloading shoe?_____

OVER----------→

Medical History: (Please check any circles that apply to you.)

○ Diabetes	○ Cancer (type) _____
○ Congestive Heart Failure	○ Kidney Disease
○ Coronary Artery Disease	○ Dialysis
○ Atrial Fibrillation	○ Gastro Esophageal Reflux (GERD)
○ Pacemaker/Defibrillator	○ Crohn's Disease
○ Deep Vein Thrombosis	○ Ulcerative colitis
○ Hypertension	○ Asthma
○ Hyperlipidemia	○ COPD
○ Peripheral Vascular Disease	○ Osteomyelitis (Bone infection)
○ Hepatitis	○ Stroke
○ Thyroid Disease	○ Other_____

Past Surgical History (dates)?:

_____

Current Medications:(Please bring list with you or verify medications with Nurse.)

Medication	Amount	How often

Signature:_____
Date:_____