NEWCare
New England Wound & Ostomy Care

PATIENT HISTORY

Name: _____ **DOB:** _____

What is the reason for your visit today? _____

Where is your wound(s) located? _____

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 the wound(s)? ☐ Yes ☐ No

Have you had any vascular studies (ABIs, arterial or venous ultrasound)? ☐ Yes ☐ No

Have you taken any antibiotics for the wound(s)? ☐ Yes ☐ No

Have you been dressing your wound(s)? ☐ Yes ☐ No

Do you have a VNS (visiting nurse)? ☐ Yes ☐ No

If yes, who? _____

Has your wound impacted your activities of daily living? ☐ Yes ☐ No

Do you wear compression / offloading shoe? ☐ Yes ☐ No

Do you experience any pain in your legs or feet while at rest? ☐ Yes ☐ No

Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking exercise? ☐ Yes ☐ No

If yes, does the pain go away when you stop walking/exercise? ☐ Yes ☐ No

Social History:

Smoking:	☐ Yes ☐ No	How much? What do you smoke?	Quit: ☐ Yes ☐ No If yes, date:
Alcohol use:	☐ Yes ☐ No	How often? Type?	
Substance use:	☐ Yes ☐ No	Describe:	
Caffeine:	☐ Yes ☐ No	How much?	
Nutrition:	Appetite: ☐ Poor ☐ Fair ☐ Good	Special diet (diabetic, low salt, etc.)? ☐ Yes ☐ No If yes, what diet?	

Medical History: Please check any that apply to you.

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

Allergy:	**Reaction:**

Past Surgical History:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

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

Medication:	**Dose:**	**How often:**

Signature: _____ Date: _____