THE WOUND CARE CENTER
A member of Appalachian Regional Healthcare System, Inc.

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Self-Assessment/Medical History Form

Date: _____

Welcome to the Wound Care Center. You are part of our team!

You have chosen the Wound Care Center "WCC" to receive treatment for your wound or ostomy. As a patient of WCC you have the right to be treated in a timely manner. In order to provide the best care for you, your appointments have been scheduled for 30 (thirty) minute intervals. You may be asked to reschedule your appointment to another time or day if you are 15 (fifteen) minutes late for your scheduled appointment. Please let us know 24-48 hours in advance if you are unable to keep your appointment. For questions regarding your treatment or to cancel your appointment please call (828) 262-9520.

Thank you,

General Information	
Name: **Age:**	**Drug Allergies and reactions:**
Primary Care Provider:	
***Physical* Address:** **State:** **Zip:**	
Pharmacy:	
Are you receiving home health? ☐ Yes ☐ No	**What physician(s) are seeing you for this wound?**
Name of Home Health Agency:	
Emergency Contact: _____	
Relationship to you: _____	
May we communicate with this person regarding your care? ☐ Yes ☐ No	

Social History
Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single
Preferred Language? English: ☐ Yes ☐ No ☐ Other _____ Do you need an interpreter? ☐ Yes ☐ No
With whom do you live? ☐ Alone ☐ Spouse ☐ Caregiver ☐ Children ☐ Nursing Home/ Assisted living ☐ Other
Smoking: ☐ Yes ☐ No If yes, how long? _____ Years How much? Packs per day? _____ If quit, when? _____
Alcohol: ☐ Yes ☐ No If yes, amount per day? _____
Recreational Drugs: ☐ Yes ☐ No Type? _____
Are there any cultural/religious beliefs that would affect your care? ☐ Yes ☐ No If yes, please explain below.

Do you have a yellow (out of facility) DNR form or a MOST form? ☐ **Yes** ☐ **No** **If yes, please allow us to make a copy for our records.**

Do you take any *non-prescription* medications? Please list all over the counter medications, herbal supplements and vitamins.		
☐ Advil/Aleve	☐ Calcium	☐ Vitamins/Herbals
☐ Antacids	☐ Decongestants	☐ Other_____
☐ Antihistamines	☐ Ibuprofen/Naproxen	_____
☐ Aspirin	☐ Tylenol	_____

Effective Date: 01/01/2012
Revised Date: 07/02/2019
Form Number: 00836

T-ZZ069

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Patient Name_____
Date of Birth_____
Phone Number_____
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Wound Information

How did your wound(s) start?

☐ Injury? Describe: _____

☐ Surgical Procedure ☐ Appeared gradually ☐ Other _____

How long have you had your wound(s)? _____

What treatments have been used on your wound?

☐ Unna boot ☐ Topical gel/ointment

☐ Medihoney ☐ Other: _____

Has your wound ever completely healed? ☐ Yes ☐ No

Have you ever been treated for a bone infection? ☐ Yes ☐ No

If yes, when and what treatment? _____

Have you taken any medications previously for the condition for which you are seeking wound care?

☐ Yes ☐ No If yes, please list: _____

Recent tests or X-ray done before coming to the Wound Care center? ☐ Yes ☐ No **If yes, what type of test, when, and where was it done?** _____

Do you have circulation problems in your legs? ☐ Yes ☐ No

If yes, have you ever had tests for circulation? ☐ Yes ☐ No Where? _____ Date: _____

Past/Current Medical History – Please check if you have or have ever had:

☐ Congestive Heart Failure	☐ COPD	☐ Arthritis
☐ Coronary Artery Disease	☐ Emphysema	☐ Broken bones
☐ Peripheral Arterial Disease	☐ Shortness of breath	☐ Osteoporosis
☐ Chest pain/palpitations	☐ Asthma	☐ Skin diseases
☐ High Blood Pressure	☐ Cough	☐ Kidney problems
☐ Heart Attack	☐ Oxygen use	☐ Parkinson's disease
☐ Poor Circulation	☐ Diabetes	☐ Seizures/Epilepsy
☐ Pain in legs	Recent Blood Sugar_____	☐ Thyroid Problems
☐ Blood clot	☐ History of infections, bone,	☐ Cancer
☐ Pacemaker	skin, other _____	☐ Stroke
☐ Ulcers/stomach problems	☐ Cellulitis	☐ Scleroderma
☐ Depression/Anxiety	☐ Lupus	☐ Other _____

Surgical History – Please list any surgeries/year

Operation/hospitalization/Injury	*Year*	*Operation/hospitalization/Injury*	*Year*

Signature of Patient/ Legal Representative ▶	Date: Time:
Name of Patient/ Legal Representative *(Please Print)* ▶	Relationship of Legal Representative ▶

(Staff Use Only)

RN/CNA Signature ▶	Date: Time:
Provider Signature ▶	Date: Time:

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