Wound Healing Center
Columbus Regional Healthcare System

NEW PATIENT INFORMATION

Identification Information

First Name: ____________________

Middle Initial: ____________________

Last Name: ____________________

SSN: ____________________

DOB: ____________________

Marital Status: ____________________

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Hispanic/Latino ☐ African American ☐ Asian/Pacific Islander ☐ Native American ☐ Other

Preferred Language: ____________________

Worker's Comp Related: ☐ Yes ☐ No

Occupation: ____________________

Employer Name: ____________________

Employer Phone: ____________________

Care Providers

Referring MD: ____________________

Speciality: ____________________

Phone: (______) __________-__________

Primary MD: ____________________

Speciality: ____________________

Phone: (______) __________-__________

Advanced Directive: ☐ Yes ☐ No

Durable Power of Attorney: ☐ Yes ☐ No

Do Not Resuscitate: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

Address 1: ____________________

Address 2: ____________________

City: ____________________

State: __________ Zip: __________

Phone: (______) __________-__________

Secondary: (______) __________-__________

Care Center: ____________________

Admission Information

How Heard: ____________________

New to Hospital: ☐ Yes ☐ No

Family/Emergency Contact Information

First Name: ____________________

Last Name: ____________________

Relationship: ____________________

Contact Phone: (______) __________-__________

Caregiver Information

Capable of Self Care: ☐ Yes ☐ No

Caregiver: ☐ Yes ☐ No

First Name: ____________________

Last Name: ____________________

Caregiver Phone: (______) __________-__________

Home Health Company: ____________________

Phone: (______) __________-__________

Nurse's Name: ____________________

PHARMACY Information

Name: ____________________

Address: ____________________

Phone: ____________________

Contact Information

Wound Healing Center
Columbus Regional Healthcare System

MEDICATION RECONCILIATION

Height: ______ Weight ______ Medications managed by ☐ Self ☐ Others ______________________

Allergies: ☐ No Known Allergies ☐ Allergies: ______________________

Pharmacy Name: ______________________ Phone: ______________

Pharmacy Address: ______________________

Date	Medication	Dose	Freq	Route

History & Review of Symptoms

UNABLE TO PROVIDE HISTORY ☐

Date ____________________

Office Use Only - Patient Label

Current Condition

____
____
____
____
____
____
____
____
____
____

MEDICATION ALLERGIES | *No known Allergies* ☐ ______________________________

____
____
____
____
____

REVIEW OF SYMPTOMS/COMPLAINTS

CHECK ONLY IF YES

Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Marked Weight Change
- ☐ Loss of Appetite

Other: ____________________

Eyes

- ☐ Double or Blurred Vision
- ☐ Excessive Tearing
- ☐ Dry Eyes
- ☐ Sensitivity to Light
- ☐ Eye Pain

Other: ____________________

Ears/Nose/Mouth/Throat

- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Post Nasal Drip
- ☐ Loss of Taste
- ☐ Loss of Smell
- ☐ Nose Bleeds
- ☐ Dental Problems
- ☐ Bleeding Gums
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Clearing Ears
- ☐ Painful/Swollen Lymph Glands

Other: ____________________

Genitourinary (GU)

- ☐ Decreased Force of Stream
- ☐ Painful Urination
- ☐ Frequency
- ☐ Blood in Urine
- ☐ Urgency
- ☐ Incontinence

Other: ____________________

Respiratory

- ☐ Cough
- ☐ Spitting Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Oxygen Use

Other: ____________________

Cardiovascular (Central/Peripheral)

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Heavy Sweating
- ☐ Difficulty Breathing on Exertion
- ☐ Swelling in Legs
- ☐ Leg Pain when Walking
- ☐ Difficulty Breathing Laying Down

Other: ____________________

Gastrointestinal (GI)

- ☐ Bowel Incontinence
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Indigestion
- ☐ Yellow Skin
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Loss of Appetite
- ☐ Hemorrhoids
- ☐ Acid Reflux

Other: ____________________

Psychiatric

- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Sleep Problems
- ☐ Suicidal
- ☐ Memory Loss
- ☐ Nervous/Tension

Other: ____________________

REVIEW OF SYMPTOMS/COMPLAINTS

CHECK ONLY IF YES

Musculoskeletal

- ☐ Backache
- ☐ Muscle Pain
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Joint Swelling
- ☐ Contractures

Other: ______________________

Integumentary (Hair/Skin/Nails)

- ☐ Change in Hair/Skin/Nails
- ☐ Skin Dryness
- ☐ Skin Lumps/Lesions
- ☐ Itching
- ☐ Skin Rash
- ☐ Sun Sensitivity
- ☐ Callus/Corns
- ☐ Prone to Skin Tears

Other: ______________________

Endocrine

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination

Other: ______________________

Hematologic/Lymphatic

- ☐ Bruise Easily
- ☐ Bleeding Tendency
- ☐ Swollen/Painful Glands

Other: ______________________

Allergic/Immunologic

- ☐ Hives
- ☐ Rhinitis
- ☐ Hay Fever

Other: ______________________

Neurologic

- ☐ Abnormal Gait
- ☐ Room Spinning/Dizziness
- ☐ Numbness/Loss of Sensation (Feet)
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness
- ☐ Headaches
- ☐ Paralysis
- ☐ Fainting

Other: ______________________

Family History *Select Family Member*

MG: Maternal Grandparents | PG: Paternal Grandparents | M: Mother | F: Father | S: Siblings

- ______ Cancer
- ______ Diabetes
- ______ Heart Disease
- ______ Hereditary Spherocytosis
- ______ Hypertension
- ______ Kidney Disease
- ______ Lung Disease
- ______ Mental Illness
- ______ Stroke
- ______ Thyroid Problems
- ______ Seizures
- ______ Tuberculosis
- ☐ No-Contributory
- ☐ None

Other: ______________________

REVIEW OF SYMPTOMS/COMPLAINTS

CHECK ONLY IF YES

Social History

Marital Status ____________________

Children ____________________

Occupation ____________________

Alcohol Use ____________________

Tobacco Use ____________________

Caffeine Use ____________________

- ☐ Suspected Abuse or Neglect
- ☐ Food, Clothing or Shelter Needs
- ☐ Transport Concerns
- ☐ Object to Blood Products
- ☐ Substance Abuse
- ☐ Illicit Drug Use

☐ Noted misuse of patient's money, food, clothing, housing and/or denial of medical care?

Cultural/Religious/Language Concerns ____________________

Financial Concerns ____________________

Support System Lacking ____________________

Unable to Care for Self ____________________

Other: ____________________

PAST MEDICAL HISTORY (Free text in Wound Expert)

Ears/Nose/Mouth/Throat

- ☐ Barotrauma
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Pharyngitis
- ☐ Dysphagia
- ☐ Tube Placement
- ☐ Myringotomy

Other: ____________________

Eyes

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Optic Neuritis
- ☐ Retinopathy

Other: ____________________

Constitutional

- ☐ Influenza Vaccine Current
- ☐ Pneumonia Vaccine
- ☐ Tetanus Toxoid Vaccine Current
- ☐ Malignant Hyperthermia
- ☐ Sleep Apnea
- ☐ Morbid Obesity
- ☐ Cachexia
- ☐ Malnourished

Other: ____________________

Respiratory

- ☐ Abnormal Chest X-Ray
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Asthma
- ☐ Aspiration
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pneumothorax
- ☐ Tuberculosis
- ☐ Upper Respiratory
- ☐ Lung Transplant
- ☐ Acute Respiratory Distress Syndrome (ARDS)
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolus
- ☐ Positive TB Test

Other: ____________________

REVIEW OF SYMPTOMS/COMPLAINTS — CHECK ONLY IF YES

Cardiovascular (Central/Peripheral)

- ☐ Coronary Artery Disease (CAD)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Myocardial Infarction (MI)
- ☐ Buerger's Disease
- ☐ Congestive Heart Failure
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Mitral Valve Prolapse
- ☐ Sternal Wound Infection
- ☐ Peripheral Vascular Disease
- ☐ Vasculititis
- ☐ Arrhythmia
- ☐ Murmur
- ☐ Angina
- ☐ Hypertension
- ☐ Varicose Veins
- ☐ Venous Disease
- ☐ Vein Stripping
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Greenfield Filter
- ☐ Heart Transplant
- ☐ Left Ventricular Assist Device (LVAD)
- ☐ Linton Procedure
- ☐ Open Heart Surgery
- ☐ Pacemaker/Defibrillator
- ☐ Stent Placement
- ☐ Peripheral Bypass Surgery
- ☐ Subfascial Endo. Perforator Surgery
- ☐ Valve Replacement

Other: ______________________

Gastrointestinal (GI)

- ☐ Diverticuliti
- ☐ Cirrhosis
- ☐ Gastric Ulcers
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Colon Cancer
- ☐ Peptic Ulcer Disease
- ☐ Crohn's Disease
- ☐ Eating Disorder
- ☐ GI Bleed
- ☐ Hemorrhoids
- ☐ Pancreatitis
- ☐ Ulcerative Colitis
- ☐ Colectomy
- ☐ Colostomy
- ☐ Ileostomy
- ☐ Fistula Site
- ☐ Cholecystectomy
- ☐ Gastro Esop. Reflux Disease (GERD)
- ☐ Radiation Cystitis

Other: ______________________

Genitourinary (GU)

- ☐ Benign Prostate Hyperplasia (BPH)
- ☐ End Stage Renal Disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostatis
- ☐ Hemodialysis
- ☐ Kidney Disease
- ☐ Peritoneal Dialysis
- ☐ Previous OB/GYN Surgery
- ☐ Prostate Cancer
- ☐ Undescended Testicle
- ☐ Radiation Cystitis
- ☐ Urinary Tract Infection

Other: ______________________

Musculoskeletal

- ☐ Arthritis
- ☐ Hip Fracture
- ☐ Osteomyelitis
- ☐ Foot Surgery
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other Fracture
- ☐ Implanted Surgical Hardware
- ☐ Joint Replacement
- ☐ Tendon/Ligament Surgery
- ☐ Amputation
- ☐ Back Surgery

Other: ______________________

REVIEW OF SYMPTOMS/COMPLAINTS

CHECK ONLY IF YES

Integumentary (Hair/Skin/Nails)

- [ ] Malignancy
- [ ] Onychomycosis
- [ ] Scleroderma
- [ ] Alopecia
- [ ] Fungal Infection

Other: ____________________

Psychiatric

- [ ] Alzheimer's
- [ ] Dementia
- [ ] Depression
- [ ] Psychosis
- [ ] Under Psychiatric Care

Other: ____________________

Neurological

- [ ] Amyotrophic Lateral Sclerosis (ALS)
- [ ] Transient Ischemic Attack (TIA)
- [ ] Hemorrhagic Stroke
- [ ] Asphasia
- [ ] Epilepsy
- [ ] Head Injury/LOC
- [ ] Stroke
- [ ] Multiple Sclerosis
- [ ] Neuropathy
- [ ] Receptive Aphasia
- [ ] CNS Trauma Injury

Other: ____________________

Endocrine

- [ ] Adrenal Disease
- [ ] Cortisone Treatment
- [ ] Thyroid Disease
- [ ] Type I Diabetes
- [ ] Type II Diabetes

Other : ____________________

Hematologic/Lymphatic

- [ ] Anticoagulant Therapy
- [ ] Lymphadenopathy
- [ ] Sickle Cell Anemia
- [ ] Anemia
- [ ] Lymphadema

Other: ____________________

Allergic/Immunologic

- [ ] Epidermolysis Bullosa
- [ ] Immune Deficiency
- [ ] Pyoderma Gangrenosum
- [ ] Rheumatoid Arthritis
- [ ] AIDS
- [ ] HIV Positive
- [ ] Lupus
- [ ] Raynaud's Disease
- [ ] Polyarteritis

Other: ____________________

SURGICAL HISTORY

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Staff Signatures

Nurse ____________________ Phys. ____________________

Date ____________________ Date ____________________