PATIENT IDENTIFICATION LABEL

Penn Medicine
Chester County Hospital

Patient History Questionnaire
The Wound Care Center

Name: _____ Date: _____
Address: _____ Home phone: _____
City: _____ Cell phone: _____
Email:_____ Date of Birth: _____ Age: _____ Sex:_____

Who referred you here? _____
Where are your open wound(s) located?_____
How long have you had your wound(s)? _____
How did your wound(s) start?_____
What do you clean your wound(s) with?_____
What treatment do you use on your wound(s)? _____
Have you had slow to heal wounds in the past? ❒No ❒Yes

Check all conditions that you currently have, or have had in the past:

❒Blood clot: Where: _____

❒Varicose Veins / Venous Disease

❒Leg swelling: ❒Right ❒Left ❒Both How long: _____

❒Arterial Disease of the Legs: ❒Right ❒Left ❒Both List treatment: _____

❒Current pain in your legs: ❒No ❒Yes At rest? ❒No ❒Yes With walking? ❒No ❒Yes

❒Heart problems ❒Chest pain or breathing problems

❒Stroke ❒Weakness in an arm or leg

❒High Cholesterol ❒Diabetes

❒Kidney disease ❒High blood pressure

❒Thyroid disease ❒Lung or breathing problems

❒Liver disease Type: _____

❒Arthritis ❒Osteoarthritis ❒Rheumatoid ❒Other : _____ Where: _____

❒No ❒Yes Do you drink alcohol? How much: _____

❒No ❒Yes Do you smoke? How much: _____

❒No ❒Yes Are you at an ideal body weight?

❒No ❒Yes Are you on dialysis?

❒No ❒Yes Are you on home oxygen?

❒No ❒Yes Have you been treated for bacterial skin infection?

❒No ❒Yes Have you been told that you have MRSA (a resistant Staph Bacteria?)

❒No ❒Yes Are you being treated for cancer?

❒No ❒Yes Are you taking any medications that might affect your immune system or healing?

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❒No ❒Yes Do you have numbness of your feet, legs, hands?

❒No ❒Yes Do you have memory problems?

❒No ❒Yes Are you troubled by anxiety or depression?

❒No ❒Yes Do you have hearing problems?

❒No ❒Yes Do you have vision problems?

❒No ❒Yes Do you have trouble walking? Please describe.

_____

❒No ❒Yes Can you walk without assistance?

❒No ❒Yes Do you use a cane/walker?

❒No ❒Yes Do you live alone?

❒No ❒Yes Do you use a brace?

❒No ❒Yes Are you confined to a bed / wheelchair?

❒No ❒Yes Do you need help with Personal Care?

❒No ❒Yes Do you need help with wound dressings?

Please tell us anything else that you think may be helpful during your treatment here:

_____
_____
_____
_____
_____
_____

List any other conditions / surgeries and the year:

_____
_____
_____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____
_____
_____

Marital Status: ❒Single ❒Married ❒Widowed ❒Divorced

What language is spoken at home? ❒English ❒Spanish ❒Other: _____ Interpreter Needed? ❒No ❒Yes

Retired: ❒No ❒Yes If No, who is your Employer: _____

Are there any Religious / Cultural Preferences that could affect your care? ❒No ❒Yes

Explain: _____
_____
_____

Patient / Responsible Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

RN Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

❒Unable to obtain a comprehensive history due to patient condition

❒History obtained by current medical record