INTEGRITY CENTER FOR HYPERBARIC MEDICINE AND WOUND CARE

New Patient History and Physical Assessment

GENERAL INFORMATION

NAME:		HOME PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
BIRTHDATE:	AGE:	SEX:	
PHYSICIAN WHO REFERRED YOU TO THE WOUND HEALING CENTER:			
NAME:	SPECIALTY:		PHONE:
ADDRESS:	CITY:	STATE:	ZIP:
PRIMARY CARE PHYSICIAN:			
NAME:	SPECIALTY:		PHONE:
ADDRESS:	CITY:	STATE:	ZIP:
HOME HEALTH CARE/NURSING HOME:		PHARMACY:	

HAVE YOU EVER BEEN A PATIENT WITH INTEGRITY TRANSITIONAL HOSPITAL?
(In-patient or Out-patient Services) ☐ YES ☐ NO

HOW DID YOU LEARN ABOUT THE WOUND HEALING CENTER? (Please check all that apply):
☐ Physician ☐ Nurse ☐ Friend/Relative ☐ Other:

WOUND HISTORY

WOUND LOCATION:

WHEN DID YOU FIRST NOTICE THE WOUND?

HOW DID YOUR WOUND START?

HAS IT EVER HEALED AND THEN RE-OPENED?

DOES YOUR WOUND PREVENT YOU FROM PERFORMING DAILY ACTIVITIES?

HOW HAVE YOU BEEN TREATING YOUR WOUND UNTIL NOW?

HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH? ☐ YES ☐ NO WHO ORDERED?

HAVE YOU HAD ANY TESTS FOR CIRCULATION ON YOUR LEGS? ☐ YES ☐ NO WHERE DONE?

WHO ORDERED?

HAVE YOU HAD ANY OTHER PROBLEMS ASSOCIATED WITH YOUR WOUND? (please check):

☐ Infection ☐ Swelling ☐ Other:

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MEDICAL HISTORY

	PATIENT		FAMILY		EXPLAIN (who, age)
	YES	NO	YES	NO	
DIABETES					
HYPERTENSION					
CANCER					
STROKE					
PARALYSIS					
PHLEBITIS/DEEP VEIN THROMBOSIS					
MISCARRIAGE					
HEART TROUBLE					
RHEUMATOID ARTHRITIS					
GOUT					
INTEGRITY TRANSITIONAL HOSPITAL?					
LUPUS					
ULCERATIVE COLITIS					
CROHN'S DISEASE					
SCLERODERMA					

DIABETES

If you have diabetes:

Do you take (please check all that apply): ☐ Insulin ☐ Oral Agents ☐ Diet Controlled

How long have you had diabetes?

Do you test your blood sugar every day? ☐ YES ☐ NO If yes, how many times/day?_____

What are your blood sugar testing results? Breakfast_____ Lunch _____ Dinner_____ Bedtime_____

MEDICATIONS

Please list all medicine you are currently taking. Include over the counter, herbal supplements and vitamins

MEDICATION	DOSAGE	HOW OFTEN

ALLERGIES

Please list all known allergies and reactions:

HOSPITALIZATION/SURGICAL HISTORY

NAME OF HOSPITAL	REASON FOR HOSPITALIZATION	DATE

NUTRITION PROFILE

	YES	NO
DIFFICULTY CHEWING OR SWALLOWING?	☐	☐
DO YOU NEED ASSISTANCE WITH EATING?	☐	☐
HAVE YOU HAD A LARGE WEIGHT LOSS OR GAIN? (please circle - Loss or Gain)	☐	☐
If yes, _____pounds in _____ months. Reason, if known:		
DO YOU FOLLOW A SPECIAL DIET?	☐	☐
Please explain:		
DO YOU HAVE ANY FOOD ALLERGIES?	☐	☐
Please explain:		
ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM?	☐	☐
Weight Loss Medications:_____ How Many Meals Do You Eat Each Day?_____		
APPETITE ☐ Good ☐ Fair ☐ Poor		
DO YOU TAKE NUTRITIONAL SUPPLEMENTS?	☐	☐
Please explain:		
HOW MUCH WATER DO YOU DRINK EACH DAY? _____ 8 ounce glasses		
DO YOU EXERCISE REGULARLY?	☐	☐

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

TOBACCO USE: ☐ NEVER ☐ PREVIOUSLY, but quit _____ years ago CURRENT, packs per day:_____

ALCOHOL USE: ☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY

DRUG USE: ☐ NEVER ☐ TYPE/FREQUENCY:

CAFFEINE USE: ☐ NEVER ☐ TYPE/FREQUENCY:

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GENERAL SYMPTOMS

	YES	NO		YES	NO
GENERAL SYMPTOMS			**CARDIOVASCULAR**		
Good General Health	☐	☐	Chest pain	☐	☐
Fatigue	☐	☐	Varicose veins	☐	☐
Height: _____ Weight:_____	☐	☐	Swelling of feet, ankles or hands	☐	☐
EYES	☐	☐	Pacemaker:(manufacturer):	☐	☐
Blurred or double vision	☐	☐	**RESPIRATORY**		
Glaucoma	☐	☐	Chronic or frequent coughs	☐	☐
Wear glasses or contacts	☐	☐	Spitting up blood	☐	☐
Cataracts	☐	☐	Shortness of breath	☐	☐
EARS/NOSE/MOUTH/THROAT			Asthma or wheezing	☐	☐
Hearing loss or ringing	☐	☐	Emphysema	☐	☐
Ear aches	☐	☐	Tuberculosis	☐	☐
Chronic sinus problems or rhinitis	☐	☐	Sleep apnea	☐	☐
Nose bleeds	☐	☐	**PSYCHIATRIC**		
Sore throat or mouth sores	☐	☐	Memory loss or confusion	☐	☐
Swollen glands in neck	☐	☐	Depression	☐	☐
GASTROINTESTINAL			Claustrophobia	☐	☐
Frequent heartburn	☐	☐	**ENDOCRINE/HEPATIC**		
Frequent diarrhea	☐	☐	Glandular or hormone problems	☐	☐
Constipation	☐	☐	Thyroid disease	☐	☐
Blood in stool	☐	☐	Excessive thirst or urination	☐	☐
INTEGUMENTARY (skin)			Heat or cold intolerance	☐	☐
Rash or itching	☐	☐	Hepatitis	☐	☐
Bleeding or bruising tendency	☐	☐	**HEMATOLOGIC/LYMPHATIC**		
Change in stool	☐	☐	Slow to heal after cuts	☐	☐
MUSCULOSKELTAL			Anemia	☐	☐
Joint pain	☐	☐	Lymphedema	☐	☐
Joint stiffness	☐	☐	Human immunodeficiency virus	☐	☐
Swelling in lower extremities	☐	☐	**GENITOURINARY**		
Weakness of muscles or joints	☐	☐	Frequent urination	☐	☐
Back pain	☐	☐	Blood in urine	☐	☐
Osteoarthritis	☐	☐	Incontinence/dribbling	☐	☐
NEUROLOGICAL			Female- irregular periods	☐	☐
Frequent/recurring headaches	☐	☐	Kidney failure	☐	☐
Light headed or dizzy	☐	☐	Dialysis	☐	☐
			Kidney transplant	☐	☐

CURRENT HEALTH

BODY PAIN	☐ NONE	☐ SOME	☐ SEVERE
ENERGY LEVEL	☐ GOOD	☐ FAIR	☐ POOR
PHYSICAL FUNCTION	☐ GOOD	☐ FAIR	☐ POOR
SOCIAL FUNCTIONING	☐ GOOD	☐ FAIR	☐ POOR
MENTAL HEALTH	☐ GOOD	☐ FAIR	☐ POOR
HEALTH PERCEPTION	☐ GOOD	☐ FAIR	☐ POOR

ACTIVITIES OF DAILY LIVING

Please check one for each item:	**COMPLETELY ABLE**	**NEED ASSISTANCE**	**NOT ABLE**
Drive Automobile	☐	☐	☐
Take medications	☐	☐	☐
Use telephone	☐	☐	☐
Care for appearance	☐	☐	☐
Use toilet	☐	☐	☐
Bath/shower	☐	☐	☐
Dress self	☐	☐	☐
Feed self	☐	☐	☐
Walk	☐	☐	☐
Get in/out of bed	☐	☐	☐
Housework	☐	☐	☐
Prepare meals	☐	☐	☐
Handle money	☐	☐	☐
Shop for self	☐	☐	☐

MEDICARE

MEDICARE RECIPIENTS ONLY:				
HAVE YOU EVER RECEIVED A KIDNEY TRANSPLANT?	☐ YES	☐ NO	DATE RECEIVED:	
DO YOU PARTICIPATE IN A DIALYSIS PROGRAM?	☐ YES	☐ NO	DATE RECEIVED:	
DO YOU PARTICIPATE IN A BLACK LUNG PROGRAM?	☐ YES	☐ NO		
Are Services Covered Under A Government Program, Such As A Research Grant?			☐ YES	☐ NO
Are you entitled to any verteran's administration (VA) benefits?			☐ YES	☐ NO

IMMUNIZATION RECORD

IMMUNIZATION (10 yrs old & younger only)	**DATE RECEIVED**
Ex. Tetanus Toxoid	

PATIENT SIGNATURE:_____ **DATE:**_____
(Or Legal Guardian/ Power Of Attorney)

NURSING SIGNATURE: _____ **DATE:**_____