ALAMEDA HEALTH SYSTEM | Creedon Advanced Wound Care

PATIENT NAME: _____

NEW PATIENT MEDICAL HISTORY

CHIEF COMPLAINT

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

HISTORY OF PRESENT ILLNESS & WOUND HISTORY

TELL US ABOUT YOUR WOUNDS:

Location: Where are your wounds located? _____

Context: How did the wound(s) occur or develop? _____

Duration: How long have you had the wound(s)? _____

Original Treatment: When did you begin to treat your wound? ☐Yesterday ☐3 to 5 days ago ☐10 to 14days ago ☐2 to 3 days ago ☐5 to 10 days ago ☐more than 14 days ago

How have you been treating your wound(s) until now?
☐Burn dressing ☐IV/IM antibiotics ☐oral antibiotics
☐I&D of abscess ☐laceration repair ☐Wound cleansing or irrigation

Have you had a fever? ☐ No ☐ Yes
Maximum temperature: If you have had a fever what was the maximum temperature?
☐Unmeasured ☐100.4 to 100.9 F ☐102.2 to 104.0 F
☐less than 100.4 F ☐101.0 to 102.1 F ☐ more than 104.0 F

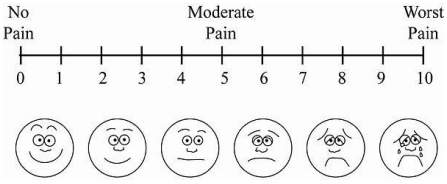
Timing: Do you have **pain** in or around the wound(s)? ☐ No ☐ Yes

If you checked YES for pain is it: ☐ Constant (never goes away) ☐ Intermittent (comes and goes)

QUALITY: Describe your pain by checking the boxes, below, that apply.

☐ Aching ☐ Burning ☐ Throbbing ☐ Stabbing ☐Shooting ☐ Sharp ☐ Dull ☐ Heavy
☐ Cramping ☐ Tender ☐ Easy to pinpoint ☐ Difficult to pinpoint

Severity: Circle the number that best describes your current level of pain



Describe any signs or symptoms associated with your wound:
Wound drainage: ☐ No drainage ☐ bloody ☐ Clear ☐ Colored
Redness around wound: ☐ No redness ☐ Improved ☐ Not Changed ☐ Worsened ☐ New Redness
Swelling: ☐ No swelling ☐ Improved ☐ Not Changed ☐ Worsened ☐ New pain

Do you have difficulty moving extremity or digit:
☐ has no difficulty moving ☐due to pain ☐ due to weakness ☐ is unable to move

Modifying Factors: Describe or list any conditions or activities that impact your wound, such as pain when walking or raising your leg: _____

Have you had any lab work done in the past month? ☐ No ☐ Yes; If Yes, Where: _____

Have you tested positive for an antibiotic resistant organism (**MRSA, VRE**)? ☐ No ☐ Yes; If Yes, Which: _____

Have you had any tests for circulation on your legs? ☐ No ☐ Yes; If Yes, Where: _____

Have you had other problems associated with your wounds? (Infection, Swelling, Other):_____

PATIENT NAME: _____

PAST MEDICAL HISTORY (GENERAL HEALTH)								
	YES	NO		YES	NO		YES	NO
Anemia			Depression			Osteoarthritis		
Anxiety			Diabetes Mellitus			Osteomyelitis (Bone Infection)		
Arrhythmia			Emphysema			Osteoporosis		
Arterial Insufficiency			GERD			Peripheral Arterial Disease		
Arthritis			Glaucoma			PVD		
Asthma			Heart Murmur			Seizures		
Cancer			Hepatitis			Sickle Cell Anemia		
Cataracts			HIV/AIDS			Stroke		
Chemo/Radiation			Hypertension			Substance Abuse		
CHF			Kidney Disease			Thyroid Disease		
Clotting Disorders			Lymphedema			Tuberculosis		
COPD			Meningitis			Ulcers (GI)		
Coronary Artery Disease			Myocardial Infarction (Heart Attack)			Varicosities/ Phlebitis		
Deep Vein Thrombosis			Nerve/ Muscle Disease			Vasculitis		
Other Please Note:								

DIABETES HISTORY (IF APPLICABLE)				
			Type I Diabetes	
			Type II Diabetes	
			How log diabetes how long?	
			Do you test your blood sugar every day	YES: NO:
What do you take for Diabetes? (Check applicable)		☐ Insulin	☐ Oral Agent	☐ DIET CONTROLLED
What are your usual blood sugar test results:	Breakfast:	Lunch:	Dinner:	Bedtime:

SURGICAL HISTORY								
	YES	NO		YES	NO		YES	NO
Appendectomy			Cosmetic Surgery			Joint Replacement		
Brain Surgery			C-Section			Small Intestine Surgery		
Breast Surgery			Eye Surgery			Spine Surgery		
CABG			Fracture Surgery			Tubal Ligation		
Cholecystectomy			Hernia Repair			Vein Surgery		
Colon Surgery			Hysterectomy			Valve Replacement		
Other Please Note:								

ALLERGIES *[LIST ALL KNOWN ALLERGIES AND REACTIONS]*

☐ **NO KNOWN ALLERGIES** ☐ LATEX / RUBBER ☐ TAPE ☐ IODINE

FOOD ALLERGIES:

MEDICATION ALLERGIES:

OTHER ALLERGIES:

PATIENT NAME: _____

REVIEW OF SYSTEMS

*[LIST ALL OF YOUR **CURRENT** COMPLAINTS AND SYMPTOMS]*

CONSTITUTIONAL (GENERAL HEALTH) (REVIEW OF SYSTEMS)		
CURRENT COMPLAINTS & SYMPTOMS	**YES**	**NO**
Activity Change		
Appetite Change		
Chills		
Diaphoresis		
Fatigue *(tired all of the time)*		
Fever		
Unexpected weight Changes		
Other Please Note:		

EAR / NOSE / MOUTH / THROAT (REVIEW OF SYSTEMS)		
CURRENT COMPLAINTS & SYMPTOMS	**YES**	**NO**
Congestion		
Dental Problems		
Ear discharge		
Ear pain		
Hearing loss		
Mouth Sores		
Sinus Pain		
Sore Throat		
Tinnitus		
Trouble Swallowing		
Other Please Note:		

EYES (REVIEW OF SYSTEMS)		
Photophobia		
Visual Disturbances		
Other Please Note:		

RESPIRATORY (REVIEW OF SYSTEMS)		
Shortness of Breath		
Stridor (whistling sound while breathing)		
Wheezing		
Other Please Note:		

CARDIOVASCULAR (CENTRAL / PERIPHERAL) (REVIEW OF SYSTEMS)		
Chest pain		
Dyspnea on exertion *(shortness of breath with activity*		
Edema *(Leg swelling)*		
Intermittent Claudication *(pain on exertion, i.e. walking to mailbox)*		

Gastrointestinal (REVIEW OF SYSTEMS)		
Abdominal pain		

CARDIOVASCULAR (CENTRAL / PERIPHERAL) (REVIEW OF SYSTEMS)		
Orthopnea *(shortness of breath when lying down)*		
Other Please Note:		

Gastrointestinal (REVIEW OF SYSTEMS)		
Diarrhea		
Nausea		
Rectal pain		
Vomiting		
Other Please Note:		

ENDOCRINE (REVIEW OF SYSTEMS)		
Cold intolerance		
Heat intolerance		
Polydipsia (excessive thirst)		
Polyphagia (excessive hunger)		
Polyuria (excessive urination)		
Other Please Note:		

Genitourinary (REVIEW OF SYSTEMS)		
Difficulty Urinating		
Dysuria(Discomfort Urinating)		
Enuresis (Nighttime loss of bladder control/ bed wetting)		
Frequent urination		
Hematuria (Blood in Urine)		
Urine Decreased		
Other Please Note:		

Musculoskeletal (REVIEW OF SYSTEMS)		
Gait Problems		
Myalgias (Pain in muscle or group of muscles)		
Other Please Note:		

Integumentary (REVIEW OF SYSTEMS)		
Color Changes		
Rash		
Wound		
Other Please Note:		

Immunological (REVIEW OF SYSTEMS)		
Environmental Allergies		
FOOD ALLERGIES		
Immunocompromised		
Other Please Note:		

Neurologic (REVIEW OF SYSTEMS)		
Dizziness		
Facial Asymmetry		
Light-headedness		
Numbness		
Seizures		
Speech Difficulty		
Syncope		
Tremors		
Weakness		
Other Please Note:		

PATIENT NAME: _____

HEMATOLOGIC/LYMPHATIC (REVIEW OF SYSTEMS)			Psychiatric (REVIEW OF SYSTEMS)		
CURRENT COMPLAINTS & SYMPTOMS	YES	NO	CURRENT COMPLAINTS & SYMPTOMS	YES	NO
Adenopathy (Swollen Glands)			Agitation		
Bruising/ Bleeds Easily			Behavior Problems		
Other Please Note:			Confusion		
			Dysphonic Mood (Feeling Unhappy, Unhappy, or Unwell)		
			Hallucinations		
			Nervous/ Anxious		
			Self-Injury		
			Suicidal Ideas		
			Other Please Note:		

FAMILY HISTORY: *PLEASE MAKE **X** FOR ALL THAT APPLY*

Relationship	No Known problem	Alcohol abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disabilites	Mental Illness	Intellectual Disabilites	Miscarriages/ Stillborn	Stroke	Vision Loss
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Aunt (Mother Side)																						
Uncle (Mother Side)																						
Aunt (Father Side)																						
Uncle (Father Side)																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						

NUTRITION ASSESSMENT

NUTRITION ASSESSMENT / SCREEN	YES	NO	GENERAL NOTES:
I have an illness or condition that made me change the kind and/or amount of food I eat? [2]			
I eat fewer than two meals per day? [3]			
I eat few fruits and vegetables, or milk products? [2]			
I have three or more drinks of beer, liquor or wine almost every day [2]			
I have tooth or mouth problems that make it hard for me to eat? [2]			
I don't always have enough money to buy the food I need? [4]			
I eat alone most of the time? [1]			
I take three or more different prescribed or over-the-counter drugs a day? [1]			
Without wanting to, I have lost or gained 10 pounds in the last six months? [2]			
I am not always physically able to shop, cook and/or feed myself? [2]			

SOCIAL HISTORY

Smoking History: ☐ Never ☐ Former ☐ Every Day ☐ Some Days ☐ Unknown

Types: ☐ Cigarettes ☐ Pipe ☐ Cigars

☐ Start Date: _____ ☐ Quit Date: _____

Packs/Day: ☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ 1 ½ pack ☐ 2 pack ☐ 3 pack

Years: ☐ ½ Year ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 10 Years

If Smoker, Are you **Ready To Quit**: ☐ Yes ☐ No **Counseling Given**: ☐ Yes ☐ No

Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown ☐ Unknown

Types: ☐ Snuff ☐ Chew

E-Cigarettes: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown ☐ Unknown

Alcohol Use: ☐ Yes ☐ Not Currently ☐ Never ☐ Defer | Type / Frequency:

Drinks Per Week: ☐ Glasses of Wine: _____ ☐ Cans of Beer: _____

☐ Shots if liquor: _____ ☐ Standard drinks or Equivalent: _____

Drug Use: ☐ Yes ☐ Not Currently ☐ Never ☐ Defer | Type / Frequency:

☐ Amphetamines ☐ Amyl Nitrate ☐ Anabolic Steroids ☐ Barbiturates ☐ Benzodiazapines ☐"Crack" Cocaine ☐ Cocaine ☐Codeine ☐Fentanyl ☐Flunitrazepam ☐GHB ☐Hashish ☐Heroin ☐Hydrocodone ☐Hydromorphone ☐ Ketamine ☐LDS ☐Marijuana ☐MDMA (ecstacy) ☐Mescaline ☐Methamphetamines ☐Methaqualone ☐Methylphenidate ☐Morphine ☐Nitrous Oxide ☐Opium ☐ Oxycodone ☐PCP ☐Psilocybin ☐Solvent Inhalants ☐ Other

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:

Sexually Active: ☐ Yes ☐ Not Currently ☐ Never ☐ Defer

Birth Control/ Protection: ☐ Abstinence ☐ Coitus Interruptus ☐ Condom Male ☐ Condom Female ☐ Diaphragm ☐Emergency Contraception ☐ Implant ☐ Injection ☐ Insert ☐ I.U.D. ☐ OCP ☐ Patch ☐ Post-Menopausal ☐ Rhythm ☐ Spermicide ☐ Sponge ☐ Surgical ☐ Male Sterilization ☐ Ring ☐ other ☐ None

Partner: ☐ Female ☐ Male

Financial Concerns: Difficulty affording basic needs (Food, Housing, Medical Care, and Heating) ?

☐ Not hard at all ☐ Not Very Hard ☐ Somewhat Hard ☐ Hard ☐ Very Hard ☐ Patient Refused

Food Needs:

Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Never True ☐ Sometimes True ☐ Often True ☐ Decline to Answer

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Never True ☐ Sometimes true ☐ often true ☐ Decline to Answer

Transportation Needs:

In the past 12 months, has lack of transportation kept you from medical appointments for from getting medications?

☐ Yes ☐ No ☐ Decline to Answer

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

☐ Yes ☐ No ☐ Decline to Answer

PHYSICAL ACTIVITY:

ON AVERAGE, HOW MANY DAYS PER WEEK DO YOU ENGAGE IN MODERATE TO STRENUOUS EXERCISE (LIKE WALKING FAST, RUNNING, JOGGING, DANCING, SWIMMING, BIKING, OR OTHER ACTIVITIES THAT CAUSE HEAVY SWEAT)?

☐ 0 DAYS ☐ 1 DAYS ☐ 2 DAYS ☐ 3 DAYS ☐ 4 DAYS ☐ 5 DAYS ☐ 6 DAYS ☐ 7 DAYS ☐ DECLINE TO ANSWER

ON AVERAGE, HOW MANY MINUTES DO YOU ENGAGE IN EXERCISE AT THIS LEVEL?

☐ 0 MIN ☐ 10 MIN ☐ 20 MIN ☐ 30 MIN ☐ 40 MIN ☐ 50 MIN ☐ 60 MIN ☐ 70 MIN ☐ 80 MIN ☐ 90 MIN ☐ 100 MIN ☐ 110 MIN ☐ 120 MIN

☐ 130 MIN ☐ 140 MIN ☐ 150 MIN + MIN ☐ DECLINE TO ANSWER

Stress:

Do you feel stress- tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?

☐ NOT AT ALL ☐ ONLY A LITTLE ☐ TO SOME EXTENT ☐RATHER MUCH ☐ VERY MUCH ☐ DECLINE TO ANSWER

Social Connections:

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

☐ NEVER ☐ ONCE A WEEK ☐ TWICE A WEEK ☐THREE TIME A WEEK ☐ MORE THAN THREE TIMES A WEEK ☐ DECLINE TO ANSWER

HOW OFTEN DO YOU GET TOGETHER WITH FRIENDS AND RELATIVES?

☐ NEVER ☐ ONCE A WEEK ☐ TWICE A WEEK ☐THREE TIME A WEEK ☐ MORE THAN THREE TIMES A WEEK ☐ DECLINE TO ANSWER

HOW OFTEN DO YOU ATTEND CHURCH OR RELIGIOUS SERVICES?

☐ NEVER ☐ 1 TO 4 TIMES PER WEEK ☐ MORE THAN 4 TIMES PER WEEK ☐ DECLINE TO ANSWER

DO YOU BELONG TO ANY CLUBS OR ORGANIZATIONS SUCH AS CHURCH GROUPS, UNION, FRATERNAL OR ATHLETIC GROUPS, OR SCHOOL GROUPS?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

HOW OFTEN DO YOU ATTENDING MEETING OF THE CLUBS OR ORGANIZATIONS YOU BELONG TO?

☐ NEVER ☐ 1 TO 4 TIMES PER WEEK ☐ MORE THAN 4 TIMES PER WEEK ☐ DECLINE TO ANSWER

Intimate Partner Violence:

Within the last year, have you been afraid of your partner or ex-partner?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

WITHIN THE LAST YEAR, HAVE YOU BEEN HUMILIATED OR EMOTIONALLY ABUSED IN OTHER WAYS BY YOUR PARTNER OR EX-PARTNER?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex- partner?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

Within the last year, have you been raped or forced to have any king of sexual activity by your partner or ex-partner?

☐ YES ☐ NO ☐ DECLINE TO ANSWER

PATIENT NAME: _____

MEDICATIONS *[LIST ALL MEDICINES YOU ARE CURRENTLY TAKING - - INCLUDE OVER THE COUNTER, HERBAL & VITAMIN SUPPLEMENTS]*

WRITE ON BACK IF MORE ROOM NEEDED			
MEDICATION	**AMOUNT**	**DOSAGE**	**HOW OFTEN**
EXAMPLE: *ASPIRIN*	*325MG*	*1 PILL*	*DAILY*

Advanced Directives and Instructions *(A copy of the document is required to be in the medical record.)*

☐ I Have an Advance Directive	☐ Advance Directive Materials Were Provided to me
☐ I Have A Living Will	☐ I Have A Copy of My Living Will for the Hospital
☐ I Have A Durable Power of Attorney for Healthcare	☐ I Do Not Want to be Resuscitated

Patient Signature: _____ **DATE:** _____ **TIME:** _____
(Or Legal Guardian/POA)

I have reviewed the New Patient Medical History with the patient / caregiver as part of the Initial Nursing Assessment.

Nurse Signature: _____ **DATE:** _____ **TIME:** _____