VEREEN
REHABILITATION CENTER
SPORTS MEDICINE

Wound Care Clinic Medical History

Name: _____ **Date:**_____

Who is your primary Medical Doctor? _____
What pharmacy do you use? _____
Are you allergic to anything? _____
What durable medical equipment company do you use (i.e. Regional, MRS, etc.)? _____
Are you a resident at a nursing home? ☐ Yes ☐ No Name: _____
If you receive Home Health services, list agency: _____
Primary language spoken: ☐ English ☐ Spanish ☐ Other: _____
Height: _____ Weight: _____

Blood disorders

☐ Anemia ☐ Sickle cell ☐ Leukemia ☐ Lymphoma ☐ Hemophilia ☐ Other _____

Cardiovascular

☐High blood pressure ☐Congestive heart failure ☐Angina/chest pain ☐Atherosclerosis ☐Raynauds Dz
☐Coronary Artery Disease ☐Peripheral vascular disease ☐Femoral popliteal bypass ☐ Lymphedema
☐Chronic venous stasis disease ☐ Dysrhythmias / Arrhythmias ☐ Fainting ☐ Blood clots ☐ Aneurysm
☐ Heart surgery ☐ Pacemaker ☐ Heart attack ☐ Dizziness ☐ CVA/Stroke When?_____
☐ Other _____ ☐ Do you fatigue easily? _____

Endocrine

Do you have: ☐ Thyroid dysfunction ☐ Addisons disease ☐ Diabetes ☐ Other _____
(If you are a diabetic fill out the following, if not skip to next section.)
Do you use: ☐ insulin ☐ non-insulin How long have you been a diabetic? _____years
Have you ever had diabetic teaching? ☐ Yes ☐ No When _____
How often is your blood sugar checked? _____
Who does it? _____ Is it recorded? ☐ Yes ☐ No
Are you on a diabetic diet? ☐ Yes ☐ No What calorie? _____
Are you currently following your diet? ☐ Yes ☐ No
When was your last Dentist visit?_____ Eye appointment?_____

Gastrointestinal/Nutrition

Do you have any problems: ☐ chewing ☐ swallowing
How many meals per day do you eat? _____ Type diet: _____
Are you taking a nutritional supplement? ☐ Yes ☐ No brand: _____ amount: _____
How is your appetite? ☐ good ☐ fair ☐ poor
Do you wear dentures? ☐ upper ☐ lower ☐ partial ☐ N / A
Have you had a weight gain recently? ☐ Yes ☐ No Loss recently? ☐ Yes ☐ No
Please check if you have or have had the following:
☐ Fecal diversion ☐ Chron's disease ☐ Obesity (overweight) ☐ Anorexia (underweight)
☐ Constipation ☐ Diarrhea ☐ Ileostomy / Colostomy ☐ Intestinal surgery ☐ Ulcers ☐ Reflux
☐ Bowel Incontinence (unable to control BM) ☐ History of bowel obstruction ☐ PEG tube if yes feeding _____
☐ Other _____

Hepatobiliary and Pancreatic

☐ Hepatitis ☐ Cirrhosis of liver ☐ Pancreatitis ☐ Cholecystectomy (gallbladder removal)
☐ Liver failure ☐ Other _____

Immunologic disorders:

☐ Aids ☐ HIV (+) ☐ Rheumatoid arthritis ☐ Other _____

Integumentary

☐ Rash ☐ Psorasis ☐ Dry skin ☐ Burns ☐ Itching ☐ Bruises easily ☐ Skin cancer
☐ Dermatitis ☐ Wounds – location _____ ☐ Skin graft – location _____

Musculoskeletal

Have you had any frequent falls? ☐ Yes ☐ No Do you use: ☐ Walker ☐ Cane ☐ Crutches
If you do not walk, are you able to transfer alone____ or with assistance___?
Do you use a wheelchair? ☐ Yes ☐ No How old is it: _____
If yes, where did you get it? _____
Do you have a special pressure relief seat? ☐ Yes ☐ No
What type of bed do you have? ☐ Hospital bed ☐ Standard mattress
Do you have a specialty pressure relief mattress on your bed? ☐ Yes ☐ No
Do you have problems moving your joints? ☐ Yes ☐ No
If yes, do you have: ☐ Pain ☐ Stiffness ☐ Other: _____
Do you wear any braces or specialty orthotics? ☐ Yes ☐ No
If yes, where and what? _____
Please check if you have or have had the following: ☐ Fractures ☐ Back pain ☐ Knee pain ☐ Neck pain
☐ Amputation – location: _____ ☐ Total joint replacement ☐ Osteomyelitis (bone infection)
☐ Contractures _____ ☐ Other _____

Neurological

☐ Headache ☐ Seizures / epilepsy ☐ CVA (stroke) ☐ Ruptured disk ☐ Disk surgery
☐ Multiple sclerosis ☐ Alzheimer's ☐ Spinal cord injury ☐ Paraplegic ☐ Quadraplegic
☐ Hemiplegia (paralyzed on side) - ☐ right ☐ left ☐ Other _____
Check if you have or have had the following: ☐ Glaucoma ☐ Cataracts ☐ Blindness ☐ Blurred vision
Do you wear: ☐ glasses ☐ contacts

Hearing: Do you have any hearing difficulties? ☐ Yes ☐ No
If yes, do you have: ☐ decreased hearing: ☐ right ear ☐ left ear
☐ deafness: ☐ right ear ☐ left ear
Do you wear hearing aides? ☐ Yes ☐ No

Speech: Do you have any difficulty speaking? ☐ Yes ☐ No
If yes, do you have: ☐ Slurred speech ☐ Decreased volume ☐ Other: _____
☐ Unable to speak ☐ Tracheostomy

Pain

Do you have pain? ☐ Yes ☐ No Location: _____
Severity (0-10) _____ Treatment / relief: _____

Psychological

☐ Depression ☐ Schizophrenia ☐ Alcoholism ☐ Panic disorder ☐ Anxiety ☐ Bipolar disorder
☐ Other _____

Reproductive

Do you have or have you had a sexually transmitted disease? ☐ Yes ☐ No
Females: Do you expect to be pregnant during the course of treatment? ☐ Yes ☐ No
Have you had: ☐ Mastectomy - ☐ Right ☐ Left ☐ Hysterectomy ☐ Cervical / uterine cancer
Males: Have you had a prostatectomy? ☐ Yes ☐ No ☐ History of prostate cancer
Other: _____

Respiratory

Do you use tobacco? ☐ Yes ☐ No
What form of tobacco? ☐ Cigar ☐ Cigarette ☐ Pipe ☐ Dip / Snuff ☐ Chewing tobacco
If you smoke cigarettes, how many packs per day? _____ , for _____ years.
Do you use oxygen? ☐ Yes ☐ No liters / min? _____
Do you have shortness of breath? ☐ Yes ☐ No
At rest? ☐ Yes ☐ No With activity? ☐ Yes ☐ No
Check if you have or have had the following: ☐ COPD ☐ Lung cancer ☐ Tuberculosis ☐ Cough
☐ Emphysema ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Other _____

Urology

Are you able to control your urination? ☐ Yes ☐ No
If no, do you use incontinence briefs? ☐ Yes ☐ No
Do you have any of the following problems with urination: ☐ Burning ☐ Pain
☐ Frequency ☐ Blood in urine
Check if you have or have had the following: ☐ Renal failure ☐ Urinary diversion (Urostomy) ☐
Prostate problems ☐ Kidney stones ☐ Foley catheter ☐ Supra pubic catheter ☐ Bladder cancer
☐ Dialysis – days of treatment: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat
☐ Other _____

Family History: List medical problems that your family members have had (Ex: mother – cancer)

_____

_____

_____

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Living arrangements: ☐ lives with spouse ☐ lives with friend ☐ lives with children
☐ other _____ ☐ lives in Nursing Home: _____
☐ lives in Personal Care Home: _____
Religious preference: ☐ Baptist ☐ Methodist ☐ Holiness ☐ Jehovah Witness ☐ Other _____
Children: ☐ Yes ☐ No ☐ Working – type of work: _____ ☐ Retired from: _____ ☐ Disabled

☐ Nurse Reviewed_____ Date:_____ Time:_____