

# EMORY DECATUR HOSPITAL

Emory Decatur  
Outpatient Wound Care  
Center

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PATIENT HISTORY			
<b>GENERAL INFORMATION</b>		<b>DATE:</b>	
Name		Home Phone	
Address		Cell Phone	
City		State	Zip
▲ E-mail	Date of Birth	Age	Sex
<b>SOCIAL HISTORY</b>			
Do you live alone: <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you drive: <input type="checkbox"/> No <input type="checkbox"/> Yes	
		Employed: <input type="checkbox"/> No <input type="checkbox"/> Yes	
What is the highest school grade you completed? <input type="checkbox"/> 1-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> Some college <input type="checkbox"/> College graduate			
Marital Status: <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed			
Do you smoke: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, for how many years: _____ How many packs per day: _____ If quit, when: _____			
Do you drink alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, amount _____		Type: _____	
Do you use recreational drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, amount: _____		Type: _____	
<b>EMERGENCY CONTACT INFORMATION</b>			
Name		Home Phone	
Relationship		Cell Phone	
<i>What physician suggested you visit the Wound Care Center®?</i>			
Name		Specialty	Phone
Address		City	State Zip
<i>Who is your primary physician?</i>			
Name		Specialty	Phone
Address		City	Phone Zip
<i>Please provide contact information (if applicable):</i>			
Home Health Agency:		Phone	
Nursing Home/Skilled Nursing Facility:		Phone	
Pharmacy:		Phone	
<i>Do you have any of the following?</i>			
Advance Directive: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Living Will: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Medical Power of Attorney: <input type="checkbox"/> Yes* <input type="checkbox"/> No	Do Not Resuscitate: <input type="checkbox"/> Yes* <input type="checkbox"/> No
*Copy required for chart. Requested by: _____		Date: _____	Time: _____
<input type="checkbox"/> Copy provided. Signature: _____		Date: _____	Time: _____
<b>WOUND HISTORY</b>			
Wound location: _____			
When did you first notice the wound? _____		Has it ever healed and then re-opened? <input type="checkbox"/> Yes* <input type="checkbox"/> No	
How did your wound start? <input type="checkbox"/> Bite <input type="checkbox"/> Blister <input type="checkbox"/> Bruise <input type="checkbox"/> Bump <input type="checkbox"/> Chemical Burn <input type="checkbox"/> Footwear <input type="checkbox"/> Frostbite			
<input type="checkbox"/> Gradually Appeared <input type="checkbox"/> Not Known <input type="checkbox"/> Other Lesion <input type="checkbox"/> Pimple <input type="checkbox"/> Pressure <input type="checkbox"/> Radiation Burn <input type="checkbox"/> Surgical			
<input type="checkbox"/> Thermal Burn <input type="checkbox"/> Trauma			
Name of Person Completing Form: _____ Relationship to Patient: _____			
Signature: _____		Date: _____	Time: _____
Reviewed By: _____		Date: _____	Time: _____



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Allergies: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Medical Health History:

- Chest pain
- Heart disease
- Blood clot in leg
- High blood pressure
- Low blood pressure
- Heart attack
- Problem with blood flow in legs
- Problem with blood vessels in legs
- Stroke
- Liver problems
- Bowel problems
- Memory loss
- Seizures
- Can't move arms
- Cant' move legs
- Lung disease
- Blood clot in lung
- Collapsed lung
- Asthma
- Uses supplemental oxygen
- Gout
- Pain in bones/joints
- Swelling of joints
- Middle ear problems
- Hyperthyroid/Hypothyroid
- Cataracts/eye disease
- Kidney disease
- On dialysis
- Low red blood cell count
- Low platelet count
- Low white blood cell count
- Swelling of arms/legs
- Problem with your immune system
- Problem with blood flow to fingers/toes
- History of burn
- History of radiation therapy
- History of chemotherapy
- Fear of being in closed space
- Depression
- Miscarriage
- Any device inside your body
- Chronic sinus problems/congestion
- Diabetes
- Hepatitis