EMORY
DECATUR
HOSPITAL

Emory Decatur
Outpatient Wound Care
Center

PATIENT HISTORY

GENERAL INFORMATION		**DATE:**	
Name		Home Phone	
Address		Cell Phone	
City		State	Zip
▲ E-mail	Date of Birth	Age	Sex

SOCIAL HISTORY

Do you live alone: ❑ No ❑ Yes Do you drive: ❑ No ❑ Yes Employed: ❑ No ❑ Yes

What is the highest school grade you completed? ❑ 1-6 ❑ 7-9 ❑ 10 ❑ 11 ❑ 12 ❑ Some college ❑ College graduate

Marital Status: ❑ Separated ❑ Divorced ❑ Married ❑ Single ❑ Widowed

Do you smoke: ❑ No ❑ Yes If Yes, for how many years: How many packs per day: If quit, when:

Do you drink alcohol: ❑ No ❑ Yes If Yes, amount Type:

Do you use recreational drugs: ❑ No ❑ Yes If Yes, amount: Type:

EMERGENCY CONTACT INFORMATION

Name	Home Phone
Relationship	Cell Phone

What physician suggested you visit the Wound Care Center®?

Name	Specialty	Phone	
Address	City	State	Zip

Who is your primary physician?

Name	Specialty	Phone	
Address	City	Phone	Zip

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

Do you have any of the following?

Advance Directive: ❑ Yes* ❑ No	Living Will: ❑ Yes* ❑ No	Medical Power of Attorney: ❑ Yes* ❑ No	Do Not Resuscitate: ❑ Yes* ❑ No

*Copy required for chart. Requested by: Date: Time:

❑ Copy provided. Signature: Date: Time:

WOUND HISTORY

Wound location:

When did you first notice the would? Has it ever healed and then re-opened? ❑ Yes* ❑ No

How did your wound start? ❑ Bite ❑ Blister ❑ Bruise ❑ Bump ❑ Chemical Burn ❑ Footwear ❑ Frostbite ❑ Gradually Appeared ❑ Not Known ❑ Other Lesion ❑ Pimple ❑ Pressure ❑ Radiation Burn ❑ Surgical ❑ Thermal Burn ❑ Trauma

Name of Person Completing Form: _____ Relationship to Patient: _____

Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

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PATIENT HISTORY

FAMILY MEDICAL HISTORY *(Please indicate with a checkmark if any of your family members have/had this condition)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

HOSPITALIZATION/SURGERY HISTORY *(Please list all)*

NAME OF HOSPITAL	REASON YOU WERE IN HOSPITAL	DATE

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

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