Ridgeview MEDICAL CENTER
Wound & Hyperbaric Healing Center

Patient Label

Please bring this information with you to your first wound care appointment. Thank you.

Patient Information

Name	
Address	
City, State & Zip Code	
Email	
Date of Birth	
Gender	☐ Male ☐ Female
Home Phone	
Cell Phone	

Today's Date	
Name of Person Completing Form	
Relationship to Patient	

Social History

Do you live alone?	☐ Yes ☐ No
Do you drive?	☐ Yes ☐ No
Are you employed?	☐ Yes ☐ No
What is the highest grade completed?	☐ 1-6 ☐ 7-9 ☐ 10-12 ☐ Some College ☐ College Graduate
Marital status?	☐ Separated ☐ Divorced ☐ Married ☐ Single ☐ Widowed
Do you smoke?	☐ Yes ☐ No If yes, for how many years? If yes, how many packs per day? If you have quit, when?
Do you use recreational/non-prescription drugs?	☐ Yes ☐ No If yes, type: If yes, amount:
Do you drink alcohol?	☐ No History ☐ Prior History ☐ Current History Type:
Caffeine Use	☐ Yes ☐ No If yes, how many years? If yes, how many cups per day?
Do you have financial concerns?	☐ Yes ☐ No
Do you have food/clothing/shelter needs?	☐ Yes ☐ No
Do you have a support system intact?	☐ Yes ☐ No
Do you have transportation concerns?	☐ Yes ☐ No

Emergency Contact Information

Name	
Relationship	
Home Phone	
Cell Phone	

Patient's Name: _____

What physician/provider suggested you visit the Wound & Hyperbaric Healing Center?

Name	
Specialty & Clinic Name	

Who is your primary care physician/provider?

Name	
Clinic Name	

Please provide contact information (if applicable):

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

Do you have any of the following? If yes, please bring a copy to your first appointment

Advance Directive	☐ Yes ☐ No
Living Will	☐ Yes ☐ No
Medical Power of Attorney	☐ Yes ☐ No
Do Not Resuscitate	☐ Yes ☐ No

Wound History

Wound location(s) and number of wounds:	
When did you first notice the wound?	
Has your wound ever healed and then re-opened?	
How did your wound start?	☐ Bite ☐ Blister ☐ Bruise ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Gradually Appeared ☐ Not Known ☐ Pimple ☐ Pressure ☐ Other Lesion ☐ Radiation Burn ☐ Surgical Burn ☐ Thermal Burn ☐ Trauma
How have you been treating your wound until now?	
Have you had any lab work done in the past month?	☐ Yes ☐ No If yes, who ordered?
Have you ever had bacteria that resisted antibiotics? (Example: MRSA, C-difficile)	☐ Yes ☐ No If yes, when?
Have you ever had a bone infection? (Example: Osteomyelitis)	☐ Yes ☐ No If yes, when?
Have you had any tests for blood flow in your legs?	☐ Yes ☐ No If yes, when? If yes, where was it done? If yes, who ordered this test?
Have you had any other problems with your wound?	☐ Infection ☐ Swelling ☐ Other

Patient's Name: _____

Patient's Medical History (Please check Yes or No for each item)

	Yes	No
Cataracts (Cloudy Vision)	☐	☐
Glaucoma (Eye Diseases)	☐	☐
Chronic Sinus Problems or Congestion	☐	☐
Middle Ear Problems	☐	☐
Ear Surgery	☐	☐
Anemia (Tired, Low Iron)	☐	☐
Hemophilia (Bleeding disorder)	☐	☐
Human Immunodeficiency Virus (HIV)	☐	☐
Lymphedema (Swelling in Legs or Arms)	☐	☐
Sickle Cell Disease	☐	☐
Aspiration	☐	☐
Asthma (Breathing Problems)	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)	☐	☐
Pneumothorax (Collapsed Lung)	☐	☐
Sleep Apnea (Stop Breaking When Sleeping)	☐	☐
Tuberculosis (Infection in the Lungs)	☐	☐
Angina (Chest Pain)	☐	☐
Arrhythmia (Skipped Heartbeat)	☐	☐
Atrial Fibrillation (Rapid Heart Rate)	☐	☐
Congestive Heart Failure	☐	☐
Coronary Artery Disease (Heart Disease)	☐	☐
Deep Vein Thrombosis (Blood Clot in Leg)	☐	☐
Pulmonary Emboli (Blood Clot in Lung)	☐	☐
Hypertension (High Blood Pressure)	☐	☐
Hypotension (Low Blood Pressure)	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐
Peripheral Arterial Disease (Problem with Blood Flow in Your Legs)	☐	☐
Stroke/CVA	☐	☐
Vasculitis (Inflammation of Your Blood Vessels)	☐	☐

	Yes	No
Cirrhosis (Liver Problems)	☐	☐
Colitis/Crohn's (Bowel Problems)	☐	☐
Hepatitis (List Type:)	☐	☐
Thyroid Disease	☐	☐
Diabetes Type 1 If yes, for how long? _____ ☐ Oral ☐ Insulin ☐ Diet	☐	☐
Diabetes Type 2 If yes, for how long?_____ ☐ Oral ☐ Insulin ☐ Diet	☐	☐
End State Renal Disease (Kidney Disease)	☐	☐
On Dialysis (Type:)	☐	☐
Lupus (Problem with Your Immune System)	☐	☐
Raynaud's Syndrome (Problem with Blood Flow to Your Fingers or Toes)	☐	☐
Scleroderma (Skin Disorder)	☐	☐
Rheumatoid Arthritis (Swelling of Joints)	☐	☐
History of Burn	☐	☐
Gout (Pain in Big Toes)	☐	☐
Osteoarthritis (Pain in Bones or Joints)	☐	☐
Dementia (Memory Loss that Gets Worse Over Time)	☐	☐
Neuropathy (Numbness in Hands or Feet)	☐	☐
Paraplegia (Cannot move Arms or Legs)	☐	☐
Quadriplegia (Can't Move Arms and Legs)	☐	☐
Received Chemotherapy	☐	☐
Surgery	☐	☐
Anorexia/Bulimia	☐	☐
Confinement Anxiety (Fear of Being in a Closed Space)	☐	☐
Peripheral Venous Disease (Problem with Blood Vessels in Your Legs)	☐	☐
Phlebitis (Inflammation of the Veins in Your Legs)	☐	☐

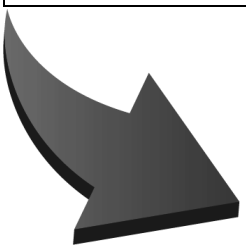
Patient's Name: _____

History of Conditions (Please Check Family Members)

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

Hospitalizations & Surgeries

Name of Hospital	Reason Why You Were in the Hospital/Type of Surgery	Date



Note: Please provide a list of your current medications or bring your current medications with you to your first visit. Include over the counter medications, herbal supplements, and vitamins.