OHSUHealth
Hillsboro Medical Center Wound Care Clinic
FORMERLY TUALITY HEALTHCARE

Patient Name: ___________________________________ Visit Date: ___________

Form completed by: _____________________________________ Relationship: ________________

What is the reason for your visit today?

About your wound(s):

<table>
<tr><td>Location:</td><td colspan="3"></td></tr>
<tr><td>Duration:</td><td colspan="3"></td></tr>
<tr><td>Cause:</td><td colspan="3"></td></tr>
<tr><td rowspan="5">Associated signs and symptoms:</td><td>Pain level?
(circle current rating)
10 Maximal
9
8 Severe
7
6 Strong
5
4 Moderate
3
2 Mild
1
0 None</td><td>Area of pain?
(mark on the diagram below)</td><td>Pain type?
(circle all that apply)

constant
comes and goes
aching
burning
cramping
dull
numb
pins and needles
sharp
shooting
stabbing
tender
throbbing</td></tr>
<tr><td colspan="3">Pain eased by?

Pain worsened by?</td></tr>
<tr><td colspan="3">Drainage? (Amount, color, odor, etc.)</td></tr>
<tr><td colspan="3">Infection? (Type of bacteria & treatment if present/known)</td></tr>
<tr><td colspan="3">Other signs/symptoms?</td></tr>
<tr><td>Current Treatment:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Are you currently receiving Home Health (therapy, nursing, etc.)? [ ] Yes [ ] No</td></tr>
</table>

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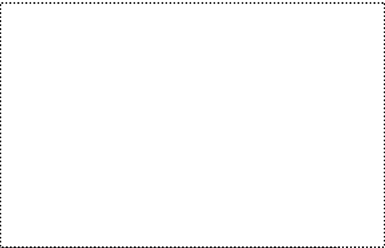

Allergies:

Do you have allergy to any of the following? (circle all applicable)

Tapes/adhesives	Wound dressing supplies
Latex/rubber	Honey product
Iodine	Animal/insect (specify): ___________________________
Chlorhexidine/Hibiclens	Food (specify): ___________________________
Alcohol	Metal (specify): ___________________________

Past medical history:

(circle all applicable)

Endocrine:	**Neurologial:**	**Respiratory:**	**Muscles/bones:**	**Cancer:**
Diabetes type - 1 or 2	Stroke	COPD	Arthritis	Type?
(Last A1C?)	TIA (mini-stroke)	Asthma	Hip fracture (R/L)	
Heart/blood vessels:	Paralysis	Pneumonia	Ankle fracture (R/L)	
Heart failure	Seizure/epilepsy	Pulm. Embolism (PE)	Bone infection	
Heart attack	Neuropathy	Sleep apnea	Gout	
High blood pressure	Parkinson's	**GU:**	**Psychiatric:**	**Skin/nail:**
Blood clot	Head injury	Irritable bowel synd.	Depression	Ulcer(s)
Atrial fibrillation	**GU:**	GI bleed	Anxiety	MRSA
Pacemaker/defibrillator	Kidney disease	Hepatitis	Bipolar	Psoriasis
Varicose vein	On dialysis	Crohn's disease	Claustrophobia	Pilonidal cyst
Peripheral artery disease	Enlarged prostate	Colitis	Alzheimer's	Fungal nail

Lymphatic: Lymphedema

Other autoimmune:
Rheumatoid arthritis MS Pyoderma gangrenosum SLE Other:

Surgical history:

(include date)

Nutrition:

Dietary restriction? [ ] No [ ] Yes (Type?)
How many cups of fluid do you drink a day? ( ) Who prepares meals? ( )
How many meals and snacks per day do you eat? (Meal: Snack:)
Please list any nutritional supplements you take (e.g. protein):

Social history:

Whom do you live with?

Name of facility you live at (if applicable):

Do you have family and/or friend(s) who can provide help? Yes / No

Do you feel unsafe at home, at work, or at school? Yes / No

Have you been hurt by someone within the past year? Yes / No

Occupation: Retired? Yes / No

Cultural, religious, or language concerns:

Are you concerned about paying for your treatment? Yes / No

Do you want to talk to anyone about finances? Yes / No

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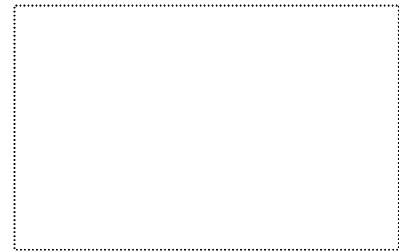

Patient Contract

OHSU Hillsboro Medical Center Wound Care Clinic is committed to providing you with the best care possible to improve/heal your wound(s). However, your active participation and commitment to the treatment plan is essential for success.

Please initial in each box and sign at the bottom, indicating your commitment to your Plan of Care discussed and presented by your wound care provider, and your willingness to Take an active role in your healing process:

	I will keep my scheduled appointment(s) and call the clinic to inform of any cancellation 24 hours prior to my appointment time. I realize that any cancellation made within 24 hours of my appointment time is marked as no show.
	I will perform wound care as directed. This may include and is not limited to (depending upon wound location): - *Avoiding direct pressure to my wound(s)* - *Bed rest* - *Limited walking or sitting* - *Wearing special boots/shoes, insoles, or an offloading cast* - *Increased protein intake depending upon my nutritional status*
	I will call the clinic with any problems, questions, or concerns regarding my wound(s) or wound care in a timely manner.
	I will report any signs or symptoms of infection/allergic reaction immediately to my wound care provider. This includes but is not limited to: - *Fever >101°F, chills* - *Increase in wound drainage, surrounding redness* - *Foul-smelling drainage, drainage in green or brown color, pus* - *Increased pain, tenderness, or swelling in my wound(s)* - *Skin rash, blistering, or any other skin reaction associated with a wound dressing(s) or any topical agent in use* - *Any other significant change related to my wound(s)*
	I will provide any new medication, medical condition, and/or allergy at each visit.

Patient (signature) Date

Patient representative (signature) Relationship to the patient Date

Clinic staff (signature) Date