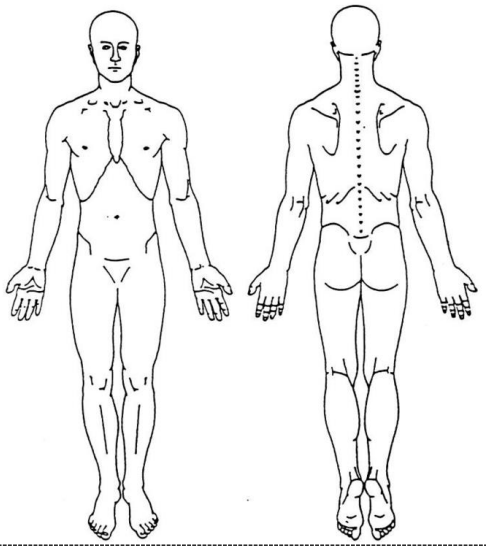
TUALITY HEALTHCARE Wound Care Clinic
An OHSU Partner

Patient Name: _____ Visit Date: _____

Form completed by: _____ Relationship: _____

What is the reason for your visit today?

About your wound(s):

Location:			
Duration:			
Cause:			
Associated signs and symptoms:	**Pain level?** (circle current rating) 10 Maximal 9 8 Severe 7 6 Strong 5 4 Moderate 3 2 Mild 1 0 None	**Area of pain?** (mark on the diagram below) 	**Pain type?** (circle all that apply) constant comes and goes aching burning cramping dull numb pins and needles sharp shooting stabbing tender throbbing
	Pain eased by? **Pain worsened by?**		
	Drainage? (Amount, color, odor, etc.)		
	Infection? (Type of bacteria & treatment if present/known)		
	Other signs/symptoms?		
Current Treatment:			

Are you currently receiving Home Health (therapy, nursing, etc.)?	[ ] Yes [ ] No
Do you wear any compression wrap/stocking?	[ ] Yes [ ] No
Do you wear any customized shoe/boot?	[ ] Yes [ ] No
Have you seen any vascular surgery specialist?	[ ] Yes [ ] No
Have you had any vascular study of your leg(s)?	[ ] Yes [ ] No

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About your health:

Current symptoms: (circle yes or no)

General:			Cardiovascular:			GU:		
Fever	Yes	No	Chest pain	Yes	No	Frequent urination	Yes	No
Chills	Yes	No	Leg pain on walking	Yes	No	Blood in urine	Yes	No
Weight loss	Yes	No	Leg swelling	Yes	No	Urinary incontinence	Yes	No
Weight gain	Yes	No	Irregular heart beat	Yes	No	Urinary catheter	Yes	No
Fatigue	Yes	No	**Respiratory:**			Urostomy	Yes	No
Falls within Last 6 mo.	Yes	No	Oxygen use	Yes	No	**Musculoskeletal:**		
Skin:			Cough	Yes	No	Muscle pain	Yes	No
Rash	Yes	No	Blood tinged sputum	Yes	No	Neck pain	Yes	No
Itching	Yes	No	Sputum production	Yes	No	Back pain	Yes	No
HENT:			Shortness of breath	Yes	No	Joint pain	Yes	No
Hearing loss	Yes	No	Wheezing	Yes	No	**Neurological:**		
Hearing aid	Yes	No	**GI:**			Dizziness	Yes	No
Nosebleeds	Yes	No	Nausea	Yes	No	Tremor	Yes	No
Congestion	Yes	No	Vomiting	Yes	No	Numbness	Yes	No
Sore throat	Yes	No	Diarrhea	Yes	No	Weakness	Yes	No
Eye:			Constipation	Yes	No	Seizures	Yes	No
Blind	Yes	No	Blood in stool	Yes	No	Paralysis	Yes	No
Blurred vision	Yes	No	Bowel incontinence	Yes	No	**Psychiatric:**		
Eye discharge	Yes	No	Ostomy	Yes	No	Depression	Yes	No
Heme:			**Endocrine:**			Anxiety	Yes	No
Easy to bleed	Yes	No	Excessive thirst	Yes	No	Insomnia	Yes	No
			Excessive urination	Yes	No	Memory loss	Yes	No

Current medications:

☞ Please attach your current medication/supplement list or you can choose to obtain a copy of medication list on file at the front desk and update it instead.

Allergies: (check / list)

[ ] No known allergies including medications

[ ] Tapes/adhesives
[ ] Latex/rubber
[ ] Iodine
[ ] Chlorhexidine
[ ] Metal: _____
[ ] Animal/insect: _____
[ ] Honey product
[ ] Alcohol
[ ] Food: _____
[ ] Medication(s): _____

Past medical history: (circle all that apply)

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

Lymphatic: Lymphedema **Autoimmune:** Rheumatoid arthritis MS Pyoderma gangrenosum SLE

Surgical history: (include date)			
Family history: (list relationship if applicable)	Diabetes?		
	Heart disease?		
	Stroke?		
	Amputation of any limb?		
	Varicose vein/venous insufficiency?		
	Peripheral artery disease?		
	Cancer?		
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
	Alcohol consumption (circle that applies): currently / previously / never		
	Current alcohol consumption (if applicable):		
	Tobacco use (circle that applies): currently – daily or occasionally / previously / never		
	Current tobacco use (if applicable): For how many years?		
	Do you use e-cigarette?	Yes	No
	Do you vape?	Yes	No
	Do you use marijuana medically?	Yes	No
	Recreational drug use: [ ] Currently (type, frequency) - [ ] Formerly (type, frequency) - [ ] Never used		

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Patient Contract

OHSU Tuality Healthcare 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