Grand River Health
Wound Care Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ **First Name:** _____ **MI:** _____

Today's Date: _____ **Doctor that referred you** _____

Date of Birth: _____ **Local Pharmacy:** _____

Chief Complaint
Please describe wound and relevant facts

_____

_____

Is this wound work related? Y N

History of Present Illness
Please answer the following questions

Location of the wound?

Abdomen Back Leg

Other: _____

_____

Onset of present wound?

_____ Days ago

_____ Weeks ago

_____ Months ago

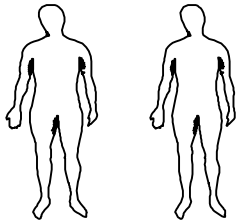
_____ Years ago

Have you been treated for present wound? Yes No

Treatment: _____

_____

Front **Back**



Previous history of other wounds?

Yes No

Description of past wound: _____

_____

Treatment of past wound: _____

_____

_____

Are you currently taking an anticoagulant? Yes No

Warfarin Xarelto

Other: _____

Past Medical and Social History
List all serious illnesses. (Example: Diabetes, Hypertension, Heart Disease).

_____ _____ _____

_____ _____ _____

List any personal past illness and/or surgeries

_____

_____

_____

Allergies and reaction:

_____

_____

List any medications you are taking and the dosage

_____

_____

_____

Do you smoke? Y N **Do you drink? Y N Socially**

Height: _____ **Weight:**_____ **B/P:** _____ **Temp:** _____ **Pulse/Resp:**_____ **O2:**_____