# Cambridge Medical Center Wound Clinic Intake Questionnaire

How would you like to be addressed (by what name)?_____

Who is your Primary Medical Doctor?_____ Who referred you to Wound Clinic?_____

What problem brings you here?_____

When did this problem start?_____

What is your primary goal of treatment?_____

**Health History**

Please describe any surgical procedures related to this problem._____

Are you currently being treated for infection?_____

Please list your allergies:_____

Have you ever been diagnosed with: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Lung Disease

☐ High Blood Pressure ☐ Circulatory Problems ☐ Digestive/Nutritional Problems

Recent weight loss/gain_____ How much/over what period of time_____

History of or current tobacco use?_____ Type/Amount_____

Cups of caffeinated drinks/day_____

**Pain**

Describe your wound pain: ☐ No pain ☐ Shooting ☐ Aching ☐ Dull ☐ Sharp ☐ Burning

Severity (1-10)_____ Pain Goal (1-10)_____

Activity or time of day when pain is worse:_____

What makes pain better?_____

**Social History**

List age and relationship of those you live with:_____

_____

Are you currently receiving: ☐ Home delivered meals ☐ In-home nursing visits

Are you receiving help with: ☐ cooking ☐ cleaning ☐ driving ☐ shopping ☐ bathing

Home: ☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living ☐ Nursing Home ☐ Other

Current occupation or work history:_____

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Written

Do you have any cultural or religious practices you would like us to address?_____

Do you feel safe at home?_____

Signature_____ Date_____

Nurse Signature_____ Date_____