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 how you have been caring for your wound and what treatment you are using now:______________

____

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 ☐ MRSA

Recent weight loss/gain or
nutritional concerns:______________________ How much/over what period of time:______________

History of or current tobacco use?______________ Type/Amount:______________________

Would you like information on stopping smoking?______________________________

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:______________________________

Where do you live?______________________________

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 ☐ Learning Barrier

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______________

WOUND CLINIC INTAKE QUESTIONNAIRE

59-01
Questionnaire

PATIENT LABEL