McLaren Wound Care & Hyperbaric Center

History & Review of Systems

Patient Name:_____ **Date:**_____

Please describe your wound/s:

Location/s:_____ Date of onset:_____
Cause of wound (if known):
_____
_____
Previous and current treatments:

List any labs, tests or procedures you have had done within the last 6 months:

If you have diabetes, what was your most recent HgbA1C:_____ date done:_____
(please obtain results from your primary care physician prior to your visit if done)

Have you ever been treated for a bone infection? Yes No
Have you ever had radiation treatments? Yes No
Do you have circulation problems in your legs? Yes No
If yes, have you ever had tests for circulation? Yes No
When and where was the testing done?_____

Ethnicity: ☐Black/African American ☐Asian ☐White ☐Hispanic ☐Native American ☐Multiracial ☐Other ☐Decline
Primary Language spoken: ☐ English ☐ Other_____ Interpreter needed: ? ☐Yes ☐No

REVIEW OF CURRENT SYMPTOMS/COMPLAINTS:

Please circle any symptoms/complaints you have today:

Constitutional:
- Fatigue
- Fever
- Chills
- Night Sweats
- Marked Weight Change
- Loss of Appetite

OTHER: _____

Eyes:
- Double or Blurred Vision
- Excessive Tearing
- Dry Eyes
- Sensitivity to Light
- Eye Pain

OTHER: _____

Ears/Nose/Mouth/Throat
- Hearing Loss
- Ear Pain
- Post Nasal Drip
- Loss of Taste
- Loss of Smell
- Nose Bleeds
- Dental Problems
- Bleeding Gums
- Sore Throat
- Hoarseness
- Difficulty clearing ears
- Painful/Swollen Lymph Glands

OTHER: _____

Respiratory
- Cough
- Spitting up Blood
- Shortness of Breath
- Wheezing
- Oxygen Use

OTHER: _____

Cardiovascular (Central / Peripheral)
- Chest Pain
- Heart Palpitations
- Heavy Sweating
- Difficulty Breathing on Exertion
- Swelling in legs
- Leg Pain when Walking
- Difficulty breathing when lying down

OTHER: _____

Gastrointestinal
- Loss of bowel control
- Change in Bowel Habits
- Abdominal Pain
- Difficulty Swallowing
- Indigestion
- Yellow Skin
- Nausea/Vomiting/Diarrhea
- Blood in Stools/Black Stools
- Constipation
- Loss of Appetite
- Hemorrhoids
- Acid Reflux

OTHER: _____

Genitourinary

Decreased Force of Stream
Painful Urination
Frequency
Blood in Urine
Urgency
Loss of bladder control

OTHER: _____

Musculoskeletal

Backache
Muscle Pain
Muscle Wasting
Muscle Weakness
Joint Swelling
Contractures

OTHER: _____

Integumentary

Change in Hair, Skin, Nails
Skin Dryness
Skin Lumps/Lesions
Itching
Skin Rash
Sun Sensitivity
Hair Loss
Callus/Corns
Prone to Skin Tears

OTHER: _____

Psychiatric

Anxiety
Claustrophobia
Sleep Problems
Suicidal
Memory Loss
Nervous / Tension
Depression

OTHER: _____

Neurologic

Difficulty walking/ falling
Room Spinning/Dizziness
Numbness/Loss of Sensation (Feet)
Tingling
Tremors
Weakness
Headaches
Paralysis
Fainting

OTHER: _____

Hematologic / Lymphatic

Bruise Easily
Bleeding Tendency
Swollen/Painful Glands

OTHER: _____

Endocrine

Cold Intolerance
Heat Intolerance
Excessive Thirst
Excessive Hunger
Excessive Urination

OTHER: _____

Allergic / Immunologic

Hives
Runny Nose
Hay Fever

OTHER: _____

NOTES:

_____

_____

_____

PAST MEDICAL HISTORY

Date last pneumonia vaccine?

_____

Date last flu vaccine?

_____

Date of last tetanus shot?

_____

Circle if you have any of the following:

Cancer
COPD/Emphysema
Diabetes
Sleep Apnea
Peripheral Vascular Disease
Circulation problem in legs
Kidney Failure
High Blood Pressure
Chest pain
Heart attack
Pain in legs with activity
Stroke
Bleeding Problems
High Cholesterol

List other medical conditions

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY

List all past surgeries

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY: Please use notes section to add information as needed.

Smoking Status: Check one response.
□ Never Smoked □ Former Smoker (Year quit_____)

□ Smoke every day □ Smoke some days
□ Unknown

Occupation_____ □ Retired

Marital Status: □Single □Married □ Divorced □Widowed

Children □ No □ Yes _____
Do you use: Alcohol? □Yes □ No
# of alcoholic beverages/day_____

Do you drink caffeinated beverages? □Yes □ No
# of caffeinated beverages/day_____

Do you have any Cultural, Religious, or Language Concerns □Yes □ No
Comments:_____

Are you able to care for yourself? □Yes □ No
If no, comments:_____

Do you have any financial concerns? □Yes □ No
If yes, comments:_____
Do you have friends/family/others to help you if needed?
□Yes □ No
Has anyone hurt or threatened you in the past 6 months?
□No □ Yes_____
Do you feel safe in your home/living situation?
□Yes □ No_____

Do you have any Food, Clothing, or Shelter Needs?
□Yes □ No
Comments:_____
Do you have any Transportation Concerns?
□No □ Yes _____
Do you object to receiving blood products?
□Yes □ No
Do you use illicit drugs? □Yes □ No
used per day _____
Do you have thoughts of harming yourself?
□Yes □ No

Live in □ House □ Apartment □ Assisted Living
□ Nursing Home □ Other _____

Live with_____

NOTES:
_____
_____
_____
_____
_____
_____

ADVANCE DIRECTIVE AND INSTRUCTIONS:
Circle if you have any of the following or if you would like information.

Advance Directive: _____

DO NOT RESUSCITATE orders

Living Will

Durable Power of Attorney for Healthcare

Copy of Advance Directive provided to facility:
□Yes □ No

Would you like information on Advance Directives? □Yes □ No

Family History

Check the condition and the family member/s who has/had the condition. If family history is unknown, check the first box, "Unknown History" and go to
the next section.

Condition	Mother	Maternal Grandparents	Father	Paternal Grandparents	Sibling	notes
Unknown History						
Cancer						
Diabetes						
Heart disease						
Hereditary Spherocytosis						
High blood pressure						
Kidney Disease						
Lung Disease						
Mental Illness						
Seizures						
Stroke						
Suicide Risk: Thoughts of harming self						
Thyroid Problem						
Tuberculosis						