Outpatient Wound Care - New Patient Questionnaire

Family History

Condition	Mother	Father	Grandparents	Sibling	Notes
Unknown History	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Lung Disease	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Alzheimer's	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Surgical History

Procedure	Date	Notes

Social History

Alcohol usage: ☐ Yes ☐ No Amount:	**Tobacco Usage:** ☐ Yes ☐ No Packs/Day:	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed	**Do you have Cultural or Religious preferences?**
Illicit Drug Usage: ☐ Yes ☐ No Drug/Amount:	**Caffeine Usage:** ☐ Yes ☐ No Type/Amount:	**Occupation:**	**Are you able to care for yourself?** ☐ Yes ☐ No
Other:			
How did you hear about our clinic? ☐ Magazine?____________________ ☐ Newspaper?____________________		☐ Billboard?_______________ ☐ Other?__________________	☐ Family/Friend?

Affix Patient ID Label Here

Medical History Questionnaire

Review of Systems: Do you experience any of the following symptoms? Check all that apply:		
Constitutional: ☐ Fever ☐ Chills ☐ Unintentional Weight Loss/Gain ☐ Unusual Fatigue ☐ Pain Location_____________________ If female, are you currently pregnant? ☐ Yes ☐ No Height:________ Weight:________	**Genitourinary:** ☐ Incontinence ☐ Fecal ☐ urine ☐ Foley Catheter ☐ Colostomy ☐ Benign Prostatic Hyperplasia ☐ Difficulty urinating **Gastrointestinal:** ☐ Constipation ☐ Irritable Bowel Syndrome ☐ Crohn's ☐ Diverticulitis ☐ Hepatitis	**HENT:** ☐ Headaches ☐ Inner Ear Pain ☐ Deafness ☐ Hearing Aids ☐ Ringing in Ears ☐ Nasal Congestion ☐ Tooth Pain ☐ Lumps or swelling of the neck **Eyes:** ☐ Recent Vision Change ☐ Glaucoma ☐ Contacts/Glasses
Neurological: ☐ Alzheimer's ☐ Dementia ☐ Neuropathy ☐ Numbness and/or tingling in feet and legs ☐ Seizures ☐ Strokes ☐ TIA ☐ History of Falls	**Cardiovascular:** ☐ Chest pain/discomfort ☐ Swelling of the legs ☐ Pain in the calves while walking ☐ Varicose veins ☐ Heart attack ☐ Atrial Fibrillation ☐ Pace maker ☐ High Cholesterol ☐ Blood clots Location:__________ Date:______	**Respiratory:** ☐ Cough ☐ COPD ☐ Emphysema ☐ Shortness of breath ☐ Tuberculosis Date:________ ☐ Pneumonia ☐ Asthma ☐ Sleep apnea ☐ Oxygen use
Musculoskeletal: ☐ Pain in joints ☐ Pain or cramping in legs/feet ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Amputation Date:________ ☐ Muscle Spasms ☐ Lymphedema	**Endocrine:** ☐ End Stage Renal Disease ☐ Diabetes ☐ Dialysis ☐ Hypoglycemia	**Integumentary:** ☐ Rashes ☐ Lesions ☐ Psoriasis ☐ Itching **History of Infection** ☐ MRSA ☐ VRE ☐ C-Diff ☐ Staph
☐ Cancer __________________ ☐ Chemo ☐ Radiation ☐ HIV/AIDS	**Psychiatric:** ☐ Depression ☐ Anxiety	**Other:**

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Start Date	Medication	Dosage	How often	For what condition?

Name of Pharmacy: Location: Telephone Number:	Name of Home Health Company: Telephone Number:

<u>List of Allergies</u>

Drug Allergy	Type of Reaction	Date of last Reaction	Food Allergy	Type of Reaction	Date of last reaction

Affix Patient ID Label Here

Patient Health Questionnaire PHQ-9

Today's Date:__________ Patient's Name:________________________ Date of Birth:_______________

Are you currently: □on medication for depression □not on medication for depression □not sure? □In counseling

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling/staying asleep, sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

□ not difficult at all □ somewhat difficult □ very difficult □ extremely difficult

In the past 2 years, have you felt depressed or sad most of the days, even if you felt okay sometimes?

Clinical Decision making based upon PHQ-9 Depression tool:

□ Yes □ No

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Symptom Score (total # of answers in shaded area) ______

Severity Score (total all points from all questions) ______