

Indiana Regional Medical Center
Indiana, Pa 15701-0788

Center for Wound Healing
Patient History

(Page 1 of 4)

Formulated: 3/04
Reviewed: 08/08
Revised: 08/08

* **GENERAL INFORMATION**

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Social Security # _____ Age _____ Sex _____

First Emergency Contact/Next of Kin: _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Relationship to patient _____

Second Emergency Contact/Next of Kin: _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Relationship to patient _____

What Physician suggested you visit the Wound Healing Center ?

Name _____ Specialty _____ Phone _____

Who is your primary physician ?

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip _____

May we provide information about your Wound Center visit to your primary care physician ? YES NO

Home Health Care Choice _____ Are you currently receiving home health services _____

Pharmacy _____ Telephone # _____

Transportation Provided By _____ Telephone # _____

Have you ever been a patient at Indiana Regional Medical Center ? Yes No

How did you learn of the Wound Healing Center (Please check all that apply)

T.V. Newspaper Radio Physician Friend/Relative Other _____

* **MEDICARE** (Only fill out if currently receiving Medicare)

Have you ever received a kidney transplant? Yes No If yes, date Received _____

Do you participate in a Dialysis Program? Yes No If yes, date Received _____

Do you participate in a Black Lung program? Yes No

Are services covered under a government program, such as a research grant? Yes No

Are you entitled to any Veteran's Administration (VA) benefits? Yes No

* **WOUND HISTORY**

Where is your wound ? _____

How long have you had this wound ? _____

How did your wound start? _____

Has it ever healed and then re-opened ? Yes _____ No _____

Does your wound prevent you from performing daily activities? Yes _____ No _____

What have you been putting on your wound ? _____

Have you had any lab work done in the past month ? Yes _____ No _____ Who Ordered _____

Have you had any tests for circulation on your legs in the past 6 months ? Yes _____ No _____ Where done _____

Who ordered ? _____

Have you had any other problems associated with your wound ? (Please circle)

Infection Swelling Other _____

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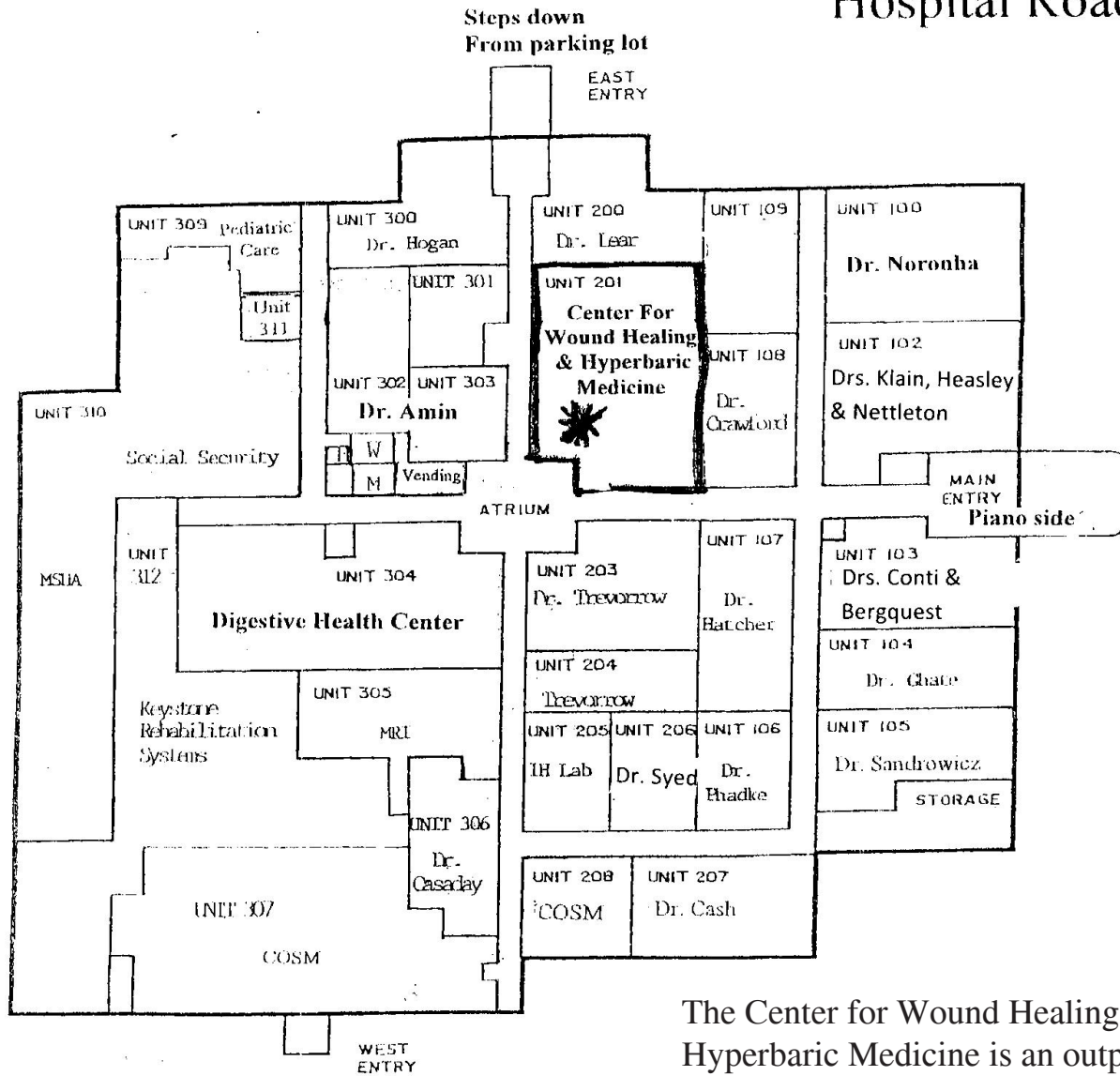
* **SYSTEM REVIEW** (Please circle yes or no for each item)

<u>GENERAL SYMPTOMS</u>		<u>CARDIOVASCULAR</u>	
Good general health lately	Yes No	Chest Pain	Yes No
Fatigue	Yes No	Varicose veins	Yes No
Height _____ Weight _____		Swelling of feet, ankles or hands	Yes No
<u>EYES</u>		Pacemaker: (manufacturer) _____	Yes No
Blurred or double vision	Yes No	<u>RESPIRATORY</u>	
Glaucoma	Yes No	Chronic or frequent coughs	Yes No
Wear glasses or contacts	Yes No	Spitting up blood	Yes No
Cataracts	Yes No	Shortness of breath	Yes No
<u>HEAD AND NECK</u>		Asthma or wheezing	Yes No
Hearing loss or ringing	Yes No	Emphysema	Yes No
Earaches	Yes No	Tuberculosis	Yes No
Chronic sinus problems or rhinitis	Yes No	Sleep Apnea	Yes No
Nose bleeds	Yes No	<u>PSYCHIATRIC</u>	
Sore throat or mouth sores	Yes No	Memory loss or confusion	Yes No
Swollen glands in neck	Yes No	Depression	Yes No
<u>GASTROINTESTINAL</u>		Claustrophobia	Yes No
Frequent heartburn	Yes No	<u>ENDOCRINE/HEPATIC</u>	
Frequent diarrhea	Yes No	Glandular or hormone problems	Yes No
Constipation	Yes No	Thyroid disease	Yes No
Blood in stool	Yes No	Excessive thirst or urination	Yes No
<u>INTEGUMENTARY(Skin)</u>		Heat or cold intolerance	Yes No
Rash or itching	Yes No	Hepatitis	Yes No
Bleeding or bruising tendency	Yes No	<u>HEMATOLOGIC</u>	
Change in mole	Yes No	Slow to heal after cuts	Yes No
<u>MUSCULOSKELETAL</u>		Anemia	Yes No
Joint Pain or Stiffness	Yes No	Lymphedema	Yes No
Swelling in lower extremities	Yes No	Human Immunodeficiency Virus	Yes No
Weakness of muscles or joints	Yes No	<u>URINARY</u>	
Back Pain	Yes No	Frequent urination	Yes No
Osteoarthritis	Yes No	Blood in urine	Yes No
<u>NEUROLOGICAL</u>		Incontinence/dribbling	Yes No
Frequent/recurring headaches	Yes No	Female - irregular periods	Yes No
Light headed or dizzy	Yes No	Kidney failure	Yes No
		Dialysis	Yes No
		Kidney transplant	Yes No

Patient Signature _____ **Date** _____
 (Or Legal Guardian/Power of Attorney)

Nurse Signature _____ **Date** _____

Hospital Road



Wayne Avenue

The Center for Wound Healing & Hyperbaric Medicine is an outpatient department of Indiana Regional Medical Center and is located in the 119 Professional Center, 1265 Wayne Avenue, Suite 201 in Indiana. The Center is located just 7/10th of a mile from IRMC and can also be accessed from Hospital Road.

119 PROFESSIONAL CENTER

1265 Wayne Avenue, Indiana PA 15701