Name: ______________________________
DOB: ____________ Age: ______
Today's Date: _______________________
Onset/Surgery: _______________________
Referring M.D. _______________________
PCP: ______________________________
Weight: _______ Height: ____________

(Above info - For MGH PT Staff to Complete)

Physical Therapy Department -
WOUND CARE CLINIC
Confidential Health History

☐**ER** ☐**EROBS** ☐**OP** ☐**WComp** ☐**NFault**

ANY CHANGES / UPDATES WE SHOULD KNOW ABOUT???
PLEASE LET OUR STAFF KNOW!!! Thank You!!!

PERSON COMPLETING THIS FORM:
☐ Patient ☐ Family (relationship): ______________________ ☐ Other: ________________________

Wound(s) / Location(s)? ____
Date Discovered Wound (MM/DD/YY): _____________
Has previous or current care been sought for this problem? ☐ No ☐ Yes – Explain: _____________________

Since discovering your wound(s), have you had: ☐ Fever / Chills ☐ Pain ☐ Dizziness / Fainting?
☐ Numbness? Where: ________________________ ☐ Swelling – Where? _________________________
☐ Changes in your Skin's Appearance? Describe: ____
☐ Unexplained Weight Gain and/or Loss (10 lbs. within the last 6 months) ☐ Tooth/Mouth Problems
☐ Other (Lack of food, not enough $$$, unhealthy eating habits, e.g.) ________________________________
☐ None of the above

Any PAIN: How much do you have right now? ***(Please circle a number.)***

Pain Rating Scale

No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Possible Pain**
	None				**Moderate**					**Severe**		

GENERAL: ***(CIRCLE: YES or NO)***

Do you exercise daily? (walking, running, e.g.)	**YES / NO**	Type? ___________________________
Do you need help with any personal care?	**YES / NO**	Explain: _________________________
Do you have homecare?	**YES / NO**	Person/Agency: ____________________
Are you physically able to shop, cook, and/or feed self?	**YES / NO**	
Do you use any assistive devices? (Cane, Walker, e.g.)	**YES / NO**	Type(s): _________________________
- Are your assistive device(s) rentals? Which one(s)? ________________________________	**YES / NO**	From Where: ______________________
Do you have any IV or Saline Lock?	**YES / NO**	
Do you have diabetes mellitus? Type: _____	**YES / NO**	Date/Time: ______ Sugar Level #: _____
Do you have high blood pressure?	**YES / NO**	
Do you have any stairs to climb at home/work?	**YES / NO**	Total at Home: ______ Work: ________
Is your gait (walking) weak / impaired / steady?	**YES / NO**	
Do you have a history of falling?	**YES / NO**	When? ___________________________
Any amputated limb(s)?	**YES / NO**	Limb(s): __________ When? _________
Do you have any circulatory problems / issues?	**YES / NO**	Where: __________________________
Do you have a history of wounds, skin ulcers, e.g.?	**YES / NO**	Where: __________________________

SUBSTANCE USE:

Smoker? ☐ No ☐ Yes – Which Type: Cigarettes / Pipes / Cigars
How many packs per day/week? _________ Years smoked? _______
Alcohol? ☐ No ☐ Yes – Do you consume more than (3) beverages daily?
Medication/Drugs? ☐ No ☐ Yes – Takes (3) prescribed meds and/or illegal drugs that affect your appetite?

HAVE YOU PREVIOUSLY HAD, OR PRESENTLY HAVE ANY OF THESE DISEASES OR CONDITIONS?		
☐ Anemia	☐ Lung Disease: _____________	☐ Osteoporosis
☐ Asthma	☐ Seizures	☐ Recent Fracture: _________________
☐ Cancer/Tumor: ___________	☐ Sleep Apnea	☐ Skin Disease
☐ Heart Attack	☐ Stroke	☐ Alcohol Abuse
☐ Diabetes Mellitus	☐ Poor Leg Circulation	☐ Meth/Cocaine Abuse
☐ GI Problems	☐ TB	☐ Gout
☐ Pacemaker	☐ Overweight	☐ Arthritis: ______________________
☐ Heart Disease	☐ Currently Pregnant (due: ____)	☐ Hernia
☐ High Blood Pressure	☐ HIV / AIDS	☐ Ulcers
☐ High Cholesterol	☐ Sexually Transmitted Disease	☐ Cancer / Tumor: _________________
☐ Kidney Disease	☐ Depression	☐ Metal Implants
☐ Liver Disease	☐ Psychiatric Illness: _________	☐ Other Medical Issues: ____________
	_________________________	______________________________

SURGICAL HISTORY	
☐ Abdominal Surgery	☐ Kidney Surgery
☐ Back/Neck Surgery	☐ Bladder Surgery
☐ Brain Surgery	☐ Prostate Surgery
☐ Breast Surgery	☐ OB/GYN Surgery
☐ CRMD / Pacemaker	☐ Orthopedic Surgery
☐ Cardiac Surgery	☐ Thoracic Surgery
☐ Cosmetic Surgery	☐ Vascular Surgery
☐ Reconstructive Surgery	☐ Other Surgery:
☐ ENT Surgery	____
☐ Eye Surgery	____

LIST OF MEDICATIONS YOU'RE CURRENTLY TAKING:

*** ☐ or See the attached medication list (provided by patient & copied by PT Staff)

	Name of Medication	**Dose**	**Frequency**
1.			
2.			
3.			
4.			
5.			

Information Reviewed By: ______________________________________ ________________
PT Wound Care Specialist or PT CMA Signature Date