BY Wound Care Internal Medicine

PATIENT INFORMATION

NAME: _____
First Middle Last

SS#: _____ DOB: _____ SEX: _____

ADDRESS: _____

HOME PHONE: _____ MOBILE PHONE: _____

EMAIL ADDRESS: _____

RACE (OPTIONAL): _____ RELIGION (OPTIONAL): _____

PREFERRED LANGUAGE: _____

OCCUPATION (OPTIONAL): _____

EMPLOYMENT STATUS: **UNEMPLOYED** **RETIRED** **FULL-TIME** **PART-TIME**

EMPLOYER NAME: _____

EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACTS

NAME: _____ RELATION TO PATIENT: _____

PHONE NO: _____ EMAIL: _____

NAME: _____ RELATION TO PATIENT: _____

PHONE NO: _____ EMAIL: _____

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PRIMARY DOCTOR

NAME: _____ PHONE NO: _____

ADDRESS: _____

REFERRING PHYSICIAN

NAME: _____ PHONE NO: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

WORKERS COMP/NO FAULT
Is this visit under Workers Comp/No Fault? YES _____ NO _____
CLAIM NUMBER: _____

ALLERGIES

MEDICATION ALLERGIES	REACTION(S)
OTHER ALLERGIES	**REACTION(S)**

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MEDICATION INFORMATION

☐ **NOT TAKING ANY MEDICATIONS OR SUPPLEMENTS**

May we obtain your medication history from the National Database?
YES _____ NO _____

PHARMACY: _____ **TEL.:** _____

MEDICATIONS AND SUPPLEMENTS	DOSAGE	HOW OFTEN

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MEDICAL HISTORY

General Illnesses (Please circle if applicable)	**Diabetes Hypertension High Cholesterol Cancer**
Heart Disease	
Lung Disease	
Disease of Stomach, Intestine and liver	
Kidney Disease	
Brain, Spine and Nerve Disease	
Thyroid and Other Endocrine Disease	
Female Reproductive System Disease	
Male Reproductive System Disease	
Skin Disease	
Head, Ear, Nose, Throat Disease	
Eye disease	
Cancer	
Blood Disease	
Blood Vessel Disease	
Muscle and Bone Disease (Orthopedic)	
Infection:	
Other:	

FEMALE ONLY: When did your last menstrual period begin?

Date: _____

☐ I do not have menstruation

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SURGICAL HISTORY

TYPE OF SURGERY	DATE	HOSPITAL/SURGEON

LIST OF PHYSICIANS AND CONSULTANTS WHOM YOU ARE SEEING

CONSULTANT	NAME(S)
Cardiology (heart)	
Pulmonary (lungs)	
Gastroenterology (stomach / intestine)	
Nephrology (kidneys)	
Neurology (brain / spine / nerves)	
Endocrinology (diabetes / thyroid)	
Oncology (cancer)	
GYN (female reproductive system)	
Urology (prostate/urinary)	
Dermatology (skin)	
ENT (ears / nose / throat / allergy)	
Surgeon	
Ophthalmology/Optometry (eye doctor)	
Podiatry (foot)	
Other: _____	

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IMMUNIZATION HISTORY

Hepatitis B _____ Hepatitis A _____ BCG _____

DTP – DTaP _____ Tetanus _____ Varicella _____

MMR _____ Polio _____ HPV _____

Shingle _____ Flu _____ Pneumonia _____

Unknown: _____ Other: _____

FAMILY MEDICAL HISTORY

Father's Medical History: (If deceased, please specify)

_____

Mother's Medical History: (If deceased, please specify)

_____

Sibling(s)' Medical History: (If deceased, please specify)

_____

Grandparents' Medical History: (If deceased, please specify)
Maternal Grandfather: _____
Maternal Grandmother: _____
Paternal Grandfather: _____
Paternal Grandmother: _____

Children's Medical History:

_____

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SOCIAL AND HABIT HISTORY

MARITAL STATUS: **Single** **Married** **Divorced** **Widowed**
Other: _____

LIVING ARRANGEMENTS: **House** **Apartment** **Nursing Home** **Assisted Living**
Other: _____

LIVING WITH: **Parents** **Spouse** **Partner** **Children** **Roommates** **Alone**
Other: _____

SEXUAL HISTORY (optional): **Are you sexually active?** YES _____ NO _____
How many partners? One _____ more than one _____

CAFFEINE: YES _____ NO _____
Type**:** **Coffee** **Tea** **Soda** Other: _____
Amount: _____/day

ALCOHOL: Yes _____ No _____ Socially Only _____ Rarely _____
Type: **Beer** **Wine** **Vodka** **Whisky** Other: _____
Amount: _____/day or week Number of Years of Consumption: _____

TOBACCO: YES _____ NO _____ QUIT _____ How Long Ago? _____
Type: **Cigar** **Cigarette** **Chewing** **Electronic** Other: _____
Amount: _____/day Number of Years of Tobacco Use: _____
Have you attempted to quit tobacco use? YES _____ NO _____
How many times? _____ **Method?** _____

OTHER SUBSTANCES: Type: _____ Amount: _____
Frequency and Length of Use: _____

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HEALTH MAINTENANCE CHECKLIST

DATE OF LAST PHYSICAL EXAM: _____

TEST	DATE	PLACE/DOCTOR
MAMMOGRAM Women age 40 y/o and older annual		
COLONOSCOPY Age 50, repeat interval per GI specialist		
BONE DENSITY Women age 65 y/o Repeat interval determined by doctor		
PAP SMEAR Women 21-65 y/o every 3 years (or interval per GYN)		
EYE EXAM Diabetics annual, Glaucoma screen		
Hepatitis C Test		
Aortic Ultrasound		
Living Will or Advanced Directive		If you have one, please bring a copy to your visit