WOUND CARE INSTITUTE of OCEAN COUNTY

Patient Questionnaire

Name: _____ Date: _____

Chief Complaint: _____

Past Medical History: Do you suffer from any of the following:

	No	Yes
Diabetes (Problems with blood sugar)	[ ]	[ ]
Congestive heart failure	[ ]	[ ]
Angina (chest pain)	[ ]	[ ]
Previous heart attack-When_____	[ ]	[ ]
Heart murmur	[ ]	[ ]
High blood pressure	[ ]	[ ]
High cholesterol	[ ]	[ ]
Stroke	[ ]	[ ]
Cancer	[ ]	[ ]
Seizures	[ ]	[ ]
Bleeding disorders	[ ]	[ ]
Thyroid disorders	[ ]	[ ]
Asthma	[ ]	[ ]
Emphysema	[ ]	[ ]
Migraine headaches	[ ]	[ ]
Blood Clots or DVT	[ ]	[ ]
Kidney disorders	[ ]	[ ]

	No	Yes
Gastrointestinal disorders	[ ]	[ ]
Tuberculosis	[ ]	[ ]
Sleep apnea	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Osteoarthritis	[ ]	[ ]
Osteopenia	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Lupus	[ ]	[ ]
Sarcoidosis	[ ]	[ ]
Hepatitis, cirrhosis, liver disease	[ ]	[ ]
Back or neck problems	[ ]	[ ]
Difficulty with anesthesia	[ ]	[ ]
Glaucoma	[ ]	[ ]
Cataracts	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Depression	[ ]	[ ]
Prostate problems	[ ]	[ ]
Sickle Cell	[ ]	[ ]

Other: _____

Past Surgical History:

Please list any surgery that you have had:	No	Yes	
Heart bypass surgery	[ ]	[ ]	
Carotid surgery	[ ]	[ ]	
Appendectomy	[ ]	[ ]	
Gall bladder surgery	[ ]	[ ]	
Foot/Ankle surgery	[ ]	[ ]	*If so, specify*_____

Other: _____

Have you ever had radiation treatment: [ ] [ ]

Allergies:	No	Yes
Do you have allergies to medications:	[ ]	[ ]
Please Specify: _____		
Latex	[ ]	[ ]
Shellfish	[ ]	[ ]
X-ray contrast	[ ]	[ ]

History Reviewed By Doctor :_____

Medications:
Please list all medications that you currently take:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you currently take:	No	Yes
Aspirin	[ ]	[ ]
Ginkgo Biloba	[ ]	[ ]
Motrin/Ibuprofen/Advil	[ ]	[ ]

Other herbal preparations: _____

Statistics: Height: _____ Weight: _____ Shoe Size: _____

Social History:
Do you now, or have you ever smoked: [ ] [ ]

If so, how much do you smoke per day?_____

If you no longer smoke, when did you quit? _____
Do you drink alcohol? [ ] [ ]

If so, how much daily or weekly? _____
Do you drink:

Coffee	[ ]	[ ]	How much a day?_____
Soda with caffeine	[ ]	[ ]	How much a day?_____
Tea	[ ]	[ ]	How much a day?_____

Family History:
Has anyone in your family ever suffered from any of the following? Who?

Bleeding problems	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Heart disease	[ ]	[ ]	_____
Hypertension	[ ]	[ ]	_____
Thyroid disorders	[ ]	[ ]	_____
Other_____	[ ]	[ ]	_____

Do you have a Living Will? [ ] [ ]
(for patients 18 yrs. & above)

Do you or your caregiver have any of the following barriers that may affect your medical care?

Cultural / Religious Barrier	[ ]	[ ]
Language Barrier	[ ]	[ ]
Visual Barrier	[ ]	[ ]
Auditory Barrier	[ ]	[ ]