Dignity Health
Sierra Nevada Memorial Hospital

Wound Healing Center

For office use only:
Nurse initials:_____ Date:_____ Isolation Y___ N___ isolation screen done Y___ N___

Name: **SS#**

In your own words, please write the reason you are here. Please be specific, putting in dates as necessary. Use the back of the form if needed.

_____
_____
_____
_____
_____
_____
_____
_____

Patient Medical, Surgical and Family History Review

*Please fill out the following information for your medical record to the best of your knowledge. Thank you for your time.

Have you ever had radiation therapy? Yes No
If so, when and body location_____

Allergies

Please circle:
Food
Tape
Iodine
Latex/Rubber
Medications *if yes, to what:_____
Other: _____
No known allergies

Do you smoke? **Yes** _____ **No**_____

Do you currently have homecare services? If so please describe?
_____
_____

Nutrition History

Recent weight loss? Yes____ No____
Special Diet? Please explain:_____
Number of meals per day:1-2____ 3-4____ 5-6____
Do you consume milk/dairy products? Yes____ No____
Do you consume fruits and vegetables? Yes____ No____

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Please list all your current Medications:*please continue on back side if needed

Name of medication dosage amount and time started when

_____
_____
_____
_____
_____
_____
_____

General Health:

Please circle if you have any of the following:

- Influenza vaccine current
- Pneumonia Vaccine current
- Tetanus vaccine current
- Glasses or contacts
- Hearing Aids
- **HISTORY OF MRSA OR VRE?**

Eyes: circle if present

- Cataracts
- Glaucoma
- Optic Neuritis
- Retinopathy

Ear/Nose/Throat/Mouth: if yes please write date occurred

- Barotrauma
- Sinusitis (current or recent)
- Tinnitus
- Pharyngitis (current or recent)
- Dysphagia
- Ear Tube Placement

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Respiratory *for remaining sections circle all that apply, please provide dates when acquired

Medical History
Abnormal chest x-ray
Acute respiratory distress syndrome
Asthma
Chronic bronchitis
COPD
Emphysema
Pneumonia
Pneumothorax
Positive TB (PPD) test
Pulmonary embolus
Tuberculosis
Upper Respiratory Infection (current)

Surgical History
Lung Transplant
Lobectomy

Cardiovascular

Medical History
Buerger's Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis (DVT)
High Cholesterol
High blood pressure
Murmur
Heart attack
Peripheral Vascular Disease
Varicose Veins
Arrhythmia
Venous Insufficiency
Venous Disease

Surgical History
CABG
Heart Transplant
LVAd
Open heart surgery
Pacemaker
Stent placement
Valve replacement
Vein Stripping

Gastrointestinal

Medical History
Cirrhosis
Crohn's Disease
Diverticulitis
Eating Disorder
Gastric ulcer
GERD
GI bleed
Hemorrhoids
Hepatitis
Hiatal Hernia
Pancreatitis
Peptic Ulcer Disease
Special Diet
Colon Cancer

Surgical History
Appendectomy
Colectomy
Colostomy
Ileostomy
Fistula site
Cholecystectomy

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Genitourinary

Medical History
BPH
Dialysis
End stage renal Disease
Kidney Disease
Kidney stones
Menopause
Dialysis
Prostate Cancer
Radiation Cystitis
Urinary Tract Infection
Breast Cancer

Surgical History
OB/GYN Surgery
*please explain:

Musculoskeletal

Medical History
Arthritis
Gout
Hip Fracture
Osteoarthritis
Osteomylitis
Osteoporosis
Other Fractures

Surgical History
Achilles Tendon Lengthening
Amputation
Back Surgery
Foot Surgery
Surgical Hardware
Joint Replacement
Tendon/ligament surgery

Hair/Skin/Nails

Medical History
Skin Cancer type:
Nail fungal infection
Hair loss
Skin Fungal Infection

Neurological

Medical History
Head or Neck Trauma
Epilepsy
Head injury with LOC
Multiple Sclerosis
Stroke
TIA
Aphasia
Neuropathy

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Psychiatric

Medical History
Alzheimer's
Dementia
Depression
Psychosis
Under current psychiatric care

Endocrine

Medical History
Adrenal Disease
Taking Cortisone
Thyroid Disease
Type I Diabetes
Type II Diabetes

Hematologic/Lymphatic

Medical History
Anemia
Taking anticoagulants
Lymph edema
Sickle Cell Anemia

Allergic/Immunologic

Medical History
AIDS
HIV Positive
Immune Deficiency
Lupus
Reynaud's Disease
Rheumatoid Arthritis

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Family History

Disease/Condition	**Family member (Mother,ect)**
Cancer Type:	_____
Kidney Disease	_____
Thyroid Problems	_____
Diabetes	_____
Lung Disease	_____
Tuberculosis	_____
Heart Disease	_____
Mental Illness	_____
Seizures	_____
Hypertension	_____
Stroke	_____

Advanced Directives

Advanced Directive	provided to hospital	Y/N
Do not resuscitate order (DNR)	provided to hospital	Y/N
Living Will	provided to hospital	Y/N
Durable power of attorney for healthcare	provided to hospital	Y/N