



WOUND EVOLUTION

NEW PATIENT REGISTRATION FORMS AND CONSENTS

Name: _____ Date of Birth: ____/____/____ Gender: Male Female
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work: (____) _____ - _____
Contact Preference: Home Cell Email Email: _____
Emergency Contact Name: _____ Emergency Contact Phone: (____) _____ - _____
Referring Physician: _____
Primary Care Physicians: _____
Any Other Specialty Physicians: _____
Pharmacy Name: _____ Phone: (____) _____ - _____ Address: _____
Wound(s) Location: _____
When did you first notice the wound(s)? _____
How did the wound(s) occur? _____

PAST MEDICAL HISTORY: Please check any of YOUR previous conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Lupus/Autoimmune | <input type="checkbox"/> Venous Disease | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Elevated Creatinine | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> COPD | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Asthma | |

PAST WOUND HISTORY: Please check any of YOUR previous conditions and elaborate if yes.

- History of wound recurrence and/or history of bone infection _____
 Currently and/or recently on antibiotics _____
 Had recent imaging (XR/MRI) where wound is located _____
 Currently have an Infectious Disease Doctor _____



PAST SURGICAL HISTORY: Please list any surgeries that may be pertinent to the wound(s) of your history below.

Type or surgery and/or procedure	Date or Year	Surgeon

Are you allergic to any medications? If yes, please list them here: _____

Patient agrees to participate in medication history retrieval: Yes: _____ No: _____

Please list all current medications, dosage, and frequency:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Do you use tobacco? Yes No Former If yes, what type of tobacco? _____

Packs per day _____ Years Smoked _____ Quit Date _____

Do you have Home Health? Yes No

If yes, please list the name of the Home Health Agency and contact information of your nurse: _____



REVIEW OF SYSTEMS: Please check ANY symptom you are experiencing.

Constitutional:

- Chills
- Fatigue
- Fever
- Weight Change
- Glasses / Contacts
- Vision Changes

Respiratory:

- Cough
- Shortness of Breath
- Oxygen Use

Cardiology:

- Chest Pain
- Dyspnea on Exertion
- Edema
- Intermittent Claudication
- Lower Extremity Resting Pain
- Orthopnea

Gastrointestinal (GI):

- Difficulty Swallowing
- Nausea / Vomiting / Diarrhea
- Stomach pain

Allergic/Immunologic:

- Frequent Rashes

Integumentary:

- Change in Hair, Nails, Skin
- Calluses / Corns
- Hyperpigmentation
- Ulcers
- Prone to Skin Tears

Musculoskeletal:

- Assistive Devices
- Decreased Activity

Neurological:

- Abnormal Gait
- Numbness
- Pain from Neuropathy
- Paralysis
- Weakness
- Seizures

Psychiatric:

- Anxiety
- Claustrophobia
- Depression
- Suicidal

Hematologic/Lymphatic:

- Bruising and/or Bleeding Disorder



FAMILY HISTORY: Please place a check in the boxes that apply.

Conditions	Mother	Maternal Grandparent	Father	Paternal Grandparent	Sibling	Child	No History
Unknown History							
Non-Contributory							
Diabetes							
Heart Disease							
Hypertension							
Lung Disease							