HOWARD COUNTY GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

HC27503-1

The Center for Wound Healing
Patient Survey

Cause of Wound:_____ **Location of Wound(s):**_____

Current Wound Treatment:_____

Height_____ **Weight**_____ **Onset Date**_____

Review of Systems: Please (✓) in the box to the left if you have experienced any of the following (blank lines are for clinician use)

HEAD / EYES / EARS / NOSE / THROAT		
☐	Frequent Headache	
☐	Blurred Vision	
☐	Glasses/Lens Used	
☐	Change in Hearing	
☐	Ringing in Ears	
☐	Dizziness	
☐	Trouble Swallowing	
☐	Sore Throat	

Comments:

RESPIRATORY		
☐	Difficulty Breathing	
☐	Persistent Cough	
☐	Asthma	
☐	Hay Fever	
☐	Emphysema	
☐	Bronchitis	
☐	Frequent Colds	
☐	Sleep Apnea	
☐	Lung Cancer	
☐	Home O_2 Use	
☐	Pulmonary Embolism	

Comments:

CARDIOVASCULAR		
☐	High Blood Pressure	
☐	Heart Disease	
☐	Heart Attack	
☐	Chest Pain/Angina	
☐	High Cholesterol	
☐	Anemia	
☐	Congestive Heart Failure	
☐	Aneurysm	
☐	Swelling in Legs	
☐	Irregular Pulses	
☐	Pacemaker	
☐	Defibrillator	
☐	Sickle Cell	
☐	Vasculitis	
☐	Blood Clot/Phlebitis	
☐	Circulation Problems	

CARDIOVASCULAR		
☐	Leg Pain	
☐	Venous Insufficiency	
☐	Varicose Veins	

Comments:

GASTROINTESTINAL / ENDOCRINE		
☐	Diabetes	
☐	Colon Cancer	
☐	Constipation	
☐	Diarrhea	
☐	Black Stools	
☐	Blood in Stools	
☐	Liver Disease	
☐	Hepatitis	
☐	Crohn's Disease	
☐	Ulcerative Colitis	
☐	Bowel Incontinence	
☐	Obesity	
☐	Heartburn	
☐	Poor Appetite	
☐	Weight Change	
☐	Hypothyroidism	

Comments:

GENITOURINARY		
☐	Frequent Urination	
☐	Urination Difficulty	
☐	Burning w/Urination	
☐	Blood in Urine	
☐	Incontinence	
☐	Impotence	
☐	Post Menopausal	
☐	Irregular Periods	
☐	Last Menstrual Period	
☐	Kidney Disease	
☐	Dialysis	
☐	Bladder Cancer	
☐	Prostate Cancer	
☐	Breast Cancer	
☐	Other:	

Comments:

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DERMATOLOGICAL		
☐	Rash	
☐	Change in Mole/Wart	
☐	New Growths	
☐	Skin Cancer	
☐	Skin Discoloration	
☐	Burn Injury	
☐	Skin Ulcer	

MUSCULOSKELETAL		
☐	Extremity Weakness	
☐	Joint Swelling	
☐	Hammer Toe	
☐	Charcot	
☐	Trophic Nails	
☐	Bunion	
☐	Arthritis	
☐	Kyphosis	
☐	Fractures	
☐	Amputation	
☐	Back Pain	

Comments:

PSYCHOSOCIAL		
☐	Depression	
☐	Anxiety	
☐	Mental Illness	
☐	Smoking: Pack/Day____	
☐	Alcohol Use	
☐	Illicit Drug Use	
☐	HIV	
☐	Employed	
☐	Unemployed	
☐	Disabled	
☐	Retired	
☐	Lives alone	
☐	Religious Affiliation	

Comments:

DERMATOLOGICAL (Continued)		
☐	Skin Graft	
☐	Ostomy	
☐	Previous Wounds	
☐	Other	
Location:		Date Healed:

Comments:

NEUROLOGICAL		
☐	Trouble w/balance	
☐	Parkinson's	
☐	Numbness/Tingling	
☐	Confusion	
☐	Seizures	
☐	Quadriplegia	
☐	Paraplegia	
☐	Hemiplegia	
☐	Memory Change	
☐	Alzheimer's	
☐	Stroke	
☐	Multiple Sclerosis	

Comments:

FUNCTIONAL		
☐ Yes ☐ No	Are you able to get out of bed with assistance?	
☐ Yes ☐ No	Are you able to walk household distances?	
☐ Yes ☐ No	Stairs to get into house/ bedroom?	
☐ Yes ☐ No	Do you exercise?	
☐ Yes ☐ No	Chair bound/bed bound?	
☐ Yes ☐ No	Assistive devices at home?	☐ Wheelchair ☐ Cane ☐ Walker

Comments:

Due to the prevalence of violence in our society we are required to ask the following:

Are you afraid of / or are you being threatened by current / former partner? ☐ No ☐ Yes _____

Within the last year have you been hit, slapped, kicked, forced into sexual activity, or otherwise physically hurt by a current / former partner? ☐ No ☐ Yes _____

Have you felt depressed or sad much of the time in the past year? ☐ No ☐ Yes _____

Date:_____ Time_____ Patient Signature:_____

Date:_____ Time_____ Clinical Signature:_____

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Date	Surgeries & Hospitalizations	Medications (include dose and frequency)
	Allergies	

Social/Educational

Primary language:_____

Preferred Learning Style: ☐ Visual ☐ Verbal ☐ Interactive

Education Level: ☐ Pre-K ☐ 1st to 8th grade ☐ 9th to 12th grade ☐ 12th grade +

To be completed by staff:

Comprehension: ☐ Grasps concept ☐ Responds to questions ☐ Demonstrates reading

Motivations: ☐ Asks questions ☐ Engaged ☐ Disinterested ☐ Denies educational need ☐ Unable to assess

Teaching factors: ☐ Language barrier ☐ Visually challenged ☐ Hearing challenged ☐ Developmental Impairment ☐ Speech impaired ☐ Cultural restriction ☐ Religious restrictions

Date:_____ Time:_____ Patient Signature:_____

Date:_____ Time:_____ Patient Representative:_____

Relationship to Patient:_____