The Center for Wound Healing Patient Survey

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

**GASTROINTESTINAL/ENDOCRINE**
- □ Diabetes
- □ Colon Cancer
- □ Constipation
- □ Diarrhea
- □ Black Stools
- □ Blood in Stools
- □ Liver Disease
- □ Hepatitis

**RESPIRATORY**
- □ Difficulty Breathing
- □ Persistent Cough
- □ Asthma
- □ Hay Fever
- □ Emphysema
- □ Bronchitis
- □ Frequent Colds

**REVIEW OF SYSTEMS**
Please check if you have experienced any of the following (blank lines are for clinician use):
- □ Difficulty Breathing
- □ Persistent Cough
- □ Asthma
- □ Hay Fever
- □ Emphysema
- □ Bronchitis
- □ Frequent Colds

**GENITOURINARY**
- □ Frequent Urination
- □ Urination Difficulty
- □ Burning w/Urination
- □ Blood in Urine

**CARDIOVASCULAR**
- □ High Blood Pressure
- □ Heart Disease
- □ Heart Attack
- □ Chest Pain/Angina
- □ High Cholesterol
- □ Anemia
- □ Congestive Heart Failure
- □ Aneurysm
- □ Swelling in Legs
- □ Irregular Pulse

**DERMATOLOGICAL**
- □ Rash
- □ Change in Mole/Wart
- □ New Growths
- □ Skin Cancer
- □ Skin Discoloration
- □ Burn Injury

**COMMENTS**
- □ Cause of Wound: ____________________________
- □ Location of Wound(s): ____________________________
- □ Current Wound Care 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):
## Review of Systems

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

### CARDIOVASCULAR Continued
- [ ] Leg Pain
- [ ] Venous Insufficiency
- [ ] Varicose Veins

### DERMATOLOGICAL Continued
- [ ] Skin Ulcer
- [ ] Skin Graft
- [ ] Ostomy

### MUSCULOSKELETAL
- [ ] Extremity Weakness
- [ ] Joint Swelling
- [ ] Hammer Toes
- [ ] Charcot
- [ ] Trophic Nails
- [ ] Bunion
- [ ] Arthritis
- [ ] Kyphosis
- [ ] Fractures
- [ ] Amputation
- [ ] Back Pain

### NEUROLOGICAL
- [ ] Trouble w/balance
- [ ] Parkinson’s
- [ ] Numbness/Tingling
- [ ] Confusion
- [ ] Seizures
- [ ] Quadriplegia
- [ ] Paraplegia
- [ ] Hemiplegia
- [ ] Memory Change
- [ ] Alzheimer’s
- [ ] Stroke

### PSYCHOSOCIAL
- [ ] Depression
- [ ] Anxiety
- [ ] Mental Illness
- [ ] Smoking: Pack/Day ________
- [ ] Alcohol Use
- [ ] Illicit Drug Use
- [ ] HIV
- [ ] Employed
- [ ] Unemployed
- [ ] Disabled
- [ ] Retired
- [ ] Lives alone
- [ ] Religious Affiliation

### FUNCTIONAL
- [ ] Yes | Are you able to get out of bed without assistance?
- [ ] No
- [ ] Yes | Are you able to walk household distances?
- [ ] No
- [ ] Yes | Stairs to get into house/bedroom?
- [ ] No
- [ ] Yes | Do you exercise?
- [ ] No
- [ ] Yes | Chair bound/bed bound?
- [ ] No
- [ ] Yes | Assistive devices at home?
- [ ] No

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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

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Patient Signature: ________________________________ Date: ________________________________

Clinical Signature: ________________________________ Date: ________________________________ Time: ________________________________
## The Center for Wound Healing-Patient Survey

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<th>Medications (include dosage and frequency)</th>
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### Allergies

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### Patient Comments

Patient Signature:  _____________________________  Date:  ________________

Patient Representative:  _____________________________  Relationship to Patient:  ________________