THE WOUND HEALING CENTER *at*

350 Boulevard | Passaic, NJ 07055 | (973) 365-4677 Fax (973) 916-5244 | www.smh-nj.com

NEW PATIENT INFORMATION

FIRST NAME MIDDLE INITIAL	HOME ADDRESS
LAST NAME	
DATE OF BIRTH GENDER	CITY STATE ZIPCODE
SOCIAL SECURITY NUMBER	PRIMARY PHONE ☐ Cell ☐ Work ☐Home
PHARMACY NAME, ADDRESS (or city), PHONE	SECONDARY PHONE ☐ Cell ☐ Work ☐Home
	EMAIL ADDRESS
HOW DO YOU WANT TO BE CONTACTED FOR APPOINTMENT REMINDERS? ☐ CALL ( ) ____________ ☐ TEXT ☐ EMAIL	ARE YOU STAYING AT A REHABILITATION FACILITY? ☐ NO ☐ YES (facility name and city below please) HOW DID YOU HEAR ABOUT US?
PREFERRED LANGUAGE	

Where is your wound? When did it start? What is the story? What other physicians are treating you for this wound?	HPI

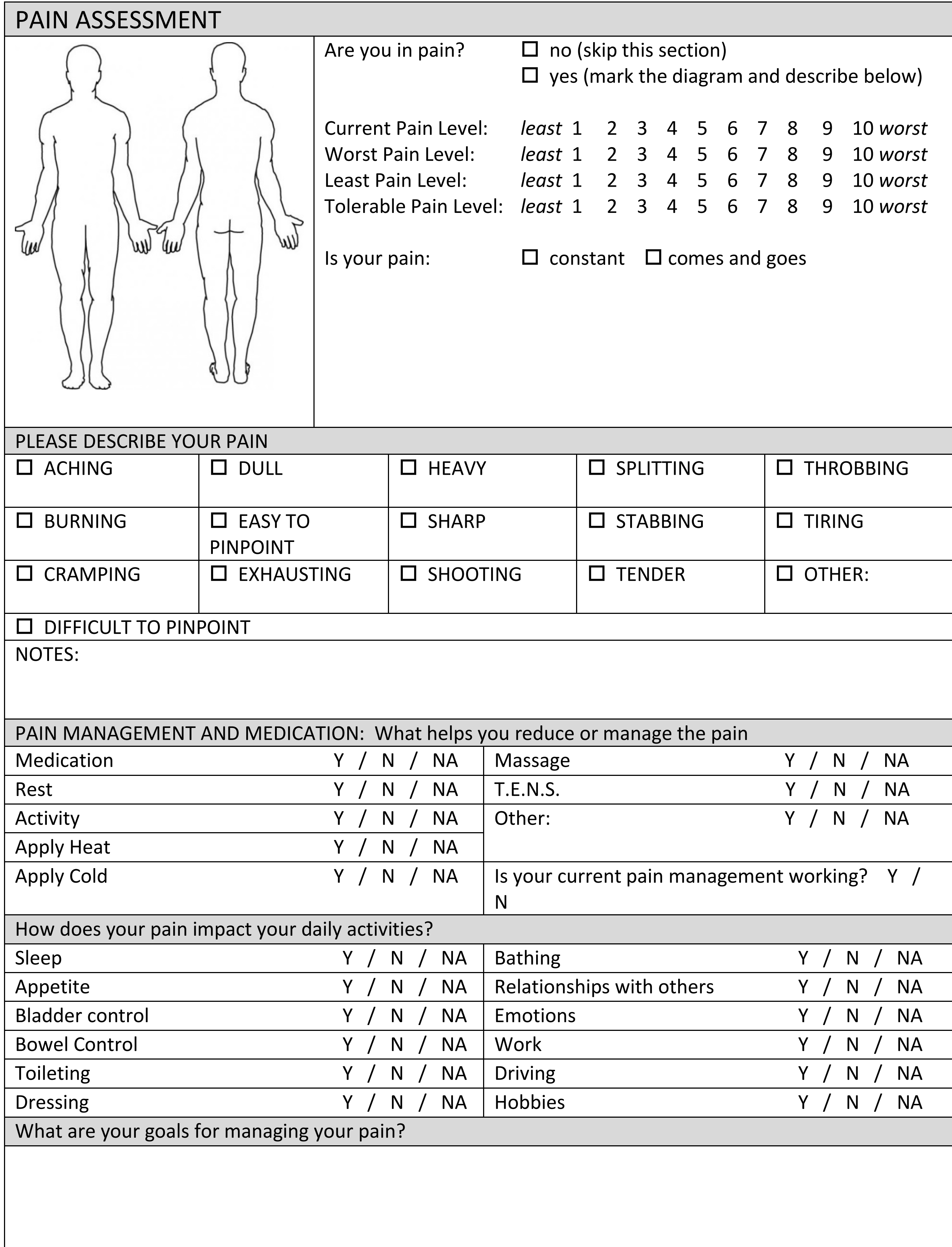
INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
POLICY NUMBER	POLICY NUMBER
NOTES	

FOR OFFICE USE ONLY MR#

Admission date to clinic:	New to St. Mary's?	Appointment
MD:	Case Mgr:	

PATIENT NAME ________________________________



PAIN ASSESSMENT

Are you in pain? ☐ no (skip this section)
☐ yes (mark the diagram and describe below)

Current Pain Level:	*least*	1	2	3	4	5	6	7	8	9	10 *worst*
Worst Pain Level:	*least*	1	2	3	4	5	6	7	8	9	10 *worst*
Least Pain Level:	*least*	1	2	3	4	5	6	7	8	9	10 *worst*
Tolerable Pain Level:	*least*	1	2	3	4	5	6	7	8	9	10 *worst*

Is your pain: ☐ constant ☐ comes and goes

PLEASE DESCRIBE YOUR PAIN

☐ ACHING	☐ DULL	☐ HEAVY	☐ SPLITTING	☐ THROBBING
☐ BURNING	☐ EASY TO PINPOINT	☐ SHARP	☐ STABBING	☐ TIRING
☐ CRAMPING	☐ EXHAUSTING	☐ SHOOTING	☐ TENDER	☐ OTHER:

☐ DIFFICULT TO PINPOINT

NOTES:

PAIN MANAGEMENT AND MEDICATION: What helps you reduce or manage the pain

Medication	Y / N / NA	Massage	Y / N / NA
Rest	Y / N / NA	T.E.N.S.	Y / N / NA
Activity	Y / N / NA	Other:	Y / N / NA
Apply Heat	Y / N / NA		
Apply Cold	Y / N / NA	Is your current pain management working? Y / N	

How does your pain impact your daily activities?

Sleep	Y / N / NA	Bathing	Y / N / NA
Appetite	Y / N / NA	Relationships with others	Y / N / NA
Bladder control	Y / N / NA	Emotions	Y / N / NA
Bowel Control	Y / N / NA	Work	Y / N / NA
Toileting	Y / N / NA	Driving	Y / N / NA
Dressing	Y / N / NA	Hobbies	Y / N / NA

What are your goals for managing your pain?

PATIENT NAME ________________________________

ALLERGIES **to foods or medications**		
Allergy to:	What happens if you take or eat it?	Severity

MEDICATIONS **Includes vitamins, supplements. You can also bring in the containers.**			
MEDICATION or SUPPLEMENT	STRENGTH (mg, mL etc)	DOSE (how many tablets)	FREQUENCY (how often)

PATIENT NAME ________________________________

REVIEW OF SYSTEMS: This is an overview of each part of your whole health picture.
Do you have any of the following:

General Health	
Y / N	Chills
Y / N	Fatigue
Y / N	Fever
Y / N	Loss of appetite
Y / N	Weight ☐up ☐down:____ lbs in ____mos
Y / N	Night sweats
Y / N	Other:

Eyes	
Y / N	Blurred vision
Y / N	Dry eyes
Y / N	Glasses / Contacts
Y / N	Vision changes
Y / N	Other:

Ear / Nose / Mouth / Throat	
Y / N	Dental problems
Y / N	Hearing loss / aid
Y / N	Nasal congestion
Y / N	Painful or swollen lymph nodes
Y / N	Sore throat
Y / N	Other:

Respiratory (Lungs)	
Y / N	Cough
Y / N	Bloody phlegm
Y / N	Shortness of breath
Y / N	Wheezing
Y / N	Oxygen use
Y / N	Other:

Cardiovascular (Heart)	
Y / N	Chest pain
Y / N	Sweating
Y / N	Difficulty breathing on exertion
Y / N	Swelling due to fluid collecting
Y / N	Leg pain while resting
Y / N	Swelling of lower legs
Y / N	Shortness of breath when lying down
Y / N	Palpitations (fast heart beat)
Y / N	Fainting

Skin	
Y / N	Change in hair, nails, skin
Y / N	Dryness
Y / N	Calluses / corns
Y / N	Change in moles
Y / N	Purple or rusty discoloration of lower legs
Y / N	Color changes to skin
Y / N	Itching
Y / N	Lesions
Y / N	Lumps
Y / N	Open sore
Y / N	Prone to skin tears (cuts)
Y / N	Rash
Y / N	Ulcer
Y / N	Other:

Endocrine (Hormones)	
Y / N	Cold intolerance
Y / N	Heat intolerance
Y / N	Excessive thirst
Y / N	Excessive urination
Y / N	Other :

Muscles & Bones	
Y / N	Decreased activity
Y / N	Joint pain
Y / N	Joint swelling
Y / N	Assistive devices (cane, walker, braces…)
Y / N	Backache
Y / N	Cannot straighten arm or leg
Y / N	Deformities
Y / N	Muscle pain
Y / N	Muscle wasting (shrinking)
Y / N	Muscle weakness
Y / N	Other:

Blood & Lymph	
Y / N	Bleeding or clotting disorders
Y / N	Blood transfusion
Y / N	Bruising
Y / N	Other:

Gastrointestinal (stomach / gut)		Neurologic (nerves)	
Y / N	Acid reflux	Y / N	Abnormal walking
Y / N	Bowel incontinence	Y / N	Dizziness
Y / N	Change in bowel habits	Y / N	Headaches
Y / N	Constipation	Y / N	Numbness
Y / N	Diarrhea	Y / N	Paralysis
Y / N	Jaundice	Y / N	Seizures
Y / N	Loss of appetite	Y / N	Fainting
Y / N	Nausea / vomiting	Y / N	Tingling
Y / N	Stomach / belly pain	Y / N	Tremors
Y / N	Other:	Y / N	Weakness
		Y / N	Other:
Urinary			
Y / N	Frequent urination	Immunologic (defense)	
Y / N	Pregnancy	Y / N	Frequent rashes
Y / N	Urgent urination (have to run!)	Y / N	Hay fever
Y / N	Urine leakage (can't hold it)	Y / N	Hives
Y / N	Other:	Y / N	Rhinitis
		Y / N	Other:
NOTES:			
		Psychiatric	
		Y / N	Anxiety
		Y / N	Claustrophobia (can't be in small spaces)
		Y / N	Depression
		Y / N	Memory loss
		Y / N	Nervousness / tension
		Y / N	Suicidal
		Y / N	Other:

PATIENT HISTORIES		
PAST MEDICAL HISTORY		
Condition	Approx. month/year	Comments
NOTES:		
PAST SURGERIES (include recent surgery relating to your current wound)		
NOTES:		

PATIENT NAME ________________________________

SOCIAL HISTORY			
Smoking Status: ☐ never smoked ☐ current every day ☐ current some days ☐ former smoker If current: how many packs per day ______ for how many years? _____			
Marital Status: ☐ married ☐single ☐ widowed ☐divorced ☐ separated ☐ looking ☺			
✓		✓	
	Children		Lives with:
	Occupation:		Receive homecare. If yes, how many hours per visit _____ and how many days per week_____
	Retired		Assisted living
	Veteran		Long-term care facility
	Service connected disability:		Skilled nursing facility
			Hospice care
	Smokeless tobacco		
	Electronic cigarettes		Independent
	Nicotine gum or patch		Unable to care for self
			Need assistance with repositioning
	Alcohol use: ☐ none ☐ social ☐ 1-2/day ☐ 4-5/day		Need assistance with weight-shifting
	Substance abuse		Need assistance with transfers
	Illicit drug use		
	Caffeine use		Mental health concerns:
	Cultural, religious, or language concerns		
	Object to blood products		In counseling
	Financial concerns		
	Transport concerns		
	Support systems lacking		
	Food, clothing or shelter needs		
	Homeless		
NOTES:			

PATIENT NAME ________________________________

FAMILY HISTORY						
Your:	Mother	Mother's Parents	Father	Father's Parents	Sibling	Child
Unknown History						
Bleeding Disorders						
Autoimmune Disease						
Cancer						
Diabetes						
Heart Disease						
Hereditary Spherocytosis						
High Blood Pressure						
Kidney Disease						
Lung Disease						
Malignant Neoplasm Of Skin						
Mental Illness						
Heart Attack (MI)						
Seizures						
Sickle Cell Anemia						
Stroke						
Suicide (including attempts)						
Tuberculosis						
Other						
NOTES:						

PATIENT NAME ________________________________

IMMUNIZATIONS – Have you received:				
	Refused	No	Yes	If yes, approximate month/year
Seasonal Influenza Shot				
Pneumonia Shot				
Hepatitis Shots				
Other:				
NOTES:				

FALL RISK		
Have you fallen recently?	☐ no ☐ yes	If yes, approximate month/year
NOTES:		

NUTRITION			
	No	Yes	If yes, is it due to:
Has your eating declined over the past 3 months?			☐ lack of appetite ☐ digestive problems ☐ chewing problems ☐ swallowing problems ☐ you are trying to lose weight
If yes, have you:	☐ Lost ☐ Gained _______ lbs over _______ ☐ weeks or ☐ months		
NOTES:			

ADVANCE DIRECTIVE - An **advance health care directive**, also known as living will, personal directive, advance directive, or advance decision, is a legal document in which you specify what actions should be taken for your health **if you are no longer able** to make decisions for yourself because of illness or incapacity.		
Do you have an advanced directive?	Y / N	
Do you have a Do Not Resuscitate (DNR) order?	Y / N	
If yes to any other the above, please bring us a copy.		
NOTES:		

EDUCATION	
What level of education have you completed:	
What language do you prefer:	
Do you prefer to use an interpreter?	☐ no ☐ yes
How do you learn best?	☐ Demonstration ☐ Explain/Verbal ☐ Video ☐ Written
Do you have difficulty hearing?	☐ no ☐ yes
What do you want to learn about? What can we help you understand?	
NOTES:	

PATIENT NAME ________________________________

ABUSE SCREENING	
Y / N	Have you been touched when you did not want to be touched?
Y / N	Have you been forced to do something against your will?
Y / N	Have you been hit, struck, slapped, or kicked?
Y / N	Have you been yelled at or spoken to in a way that made you feel bad about yourself?
Y / N	Are you afraid of anyone?
Y / N	Are you being threatened?
Y / N	Has your money been used in a way you did not like?
Y / N	Have you given away anything when you did not want to?
Y / N	Do you have easy access to a phone?
Y / N	Do you have enough privacy in your home?
Y / N	Has anyone forced you to do things you don't want to do?
Y / N	Do you trust most of the people in your family?
Y / N	Has anyone taken, without your permission, things that belong to you?
Y / N	Do you have enough food, clothing, shelter, and medication available at all times?
Y / N	Can you leave your home when you want?
Y / N	Do you have the necessary aides such as dentures, cane, walker, hearing aid?
Y / N	Do you live with anyone or have any close family members who abuse drugs or alcohol, or have emotional/psychological condition?
Y / N	Do you take your own medication and/or get around by yourself?
Y / N	Have you recently felt down, depressed or hopeless?
Y / N	Have you noticed less interest or pleasure in doing things?
Y / N	Do you have thoughts of harming/killing yourself?
Y / N	Have you ever tried to hurt yourself before?
Y / N	Have you recently thought about harming or killing others?
NOTES:	