Name:________________________ Today's Date: ____________

Primary Physician: ________________ Physician's Phone Number:__________

Check (X) if you have any of these conditions

	Past Medical History	Year		Past Surgeries	Year
❑	Diabetes		❑	Cataract Surgery	
❑	High Blood Pressure		❑	Thyroid Surgery	
❑	Heart Attack		❑	Lunger Surgery	
❑	Heart Failure (CHF)		❑	Heart Surgery	
❑	High Cholesterol		❑	Gallbladder Removal	
❑	Stroke (CVA)		❑	Appendectomy	
❑	Asthma/Emphysema		❑	Hernia Repair	
❑	Varicose Veins		❑	Vascular Surgery	
❑	Seizures		❑	Amputation	
❑	Cancer		❑	Cancer Surgery	
❑	Pulmonary/Lung Disease		❑	Back Surgery	
❑	Hepatitis/Jaundice		❑	Breast Surgery	
❑	Kidney Disease/Dialysis		❑	Angioplasty	
❑	Pacemaker				
❑	Poor Circulation/legs		❑	Heart Arrythmias	
❑	Arthritis		❑	Radiation Treatment	
❑	Bleeding Stomach Ulcers		❑	TB Tuburculosis	
❑	Psychiatric Problems/Depression		❑	Bone Infection	
❑	Thyroid Disease		❑	Lupus	
	List Other Medical Conditions			**List Other Surgeries**	

Check (X) if you have any of these problems

❑	Leg ulcers/wounds		❑	HIV Positive	
❑	Other skin conditions		❑	Gout	
❑	Vision Problems		❑	Swelling of Ankles	
❑	Ear Problems		❑	Loss of Hearing	
❑	Sinus Problems		❑	Loss of Vision	
❑	Chest Pain, Angina		❑	Rapid Heart Beat	
❑	Breathing Problems		❑	Hay Fever	
❑	Shortness of Breath		❑	Coughing up Blood	
❑	Chronic Cough		❑	Pain in Legs walking	
❑	Weak Heart		❑	Numbness in Legs	
❑	Irregular Heart Beat		❑	Weakness arms/legs	
❑	Poor Appetite		❑	Poor Circulation	
❑	Loss of Weight		❑	Radiation Therapy	
❑	Bleeding disorder		❑	Seizure Disorder	
❑	Claustrophobia		❑	Blood Clots in legs	

MEMORIAL HERMANN

Hyperbaric and Advanced Wound Care Center
Health History and Patient Assessment

	Yes	No		Yes	No
Have you ever had hyperbaric oxygen (HBO) treatments?			Have you ever been treated by a Wound Care Clinic?		
Have you ever had chemotherapy?			Have you ever had a collapsed lung?		
Have you ever had a seizure?			Weight loss greater than 10 Lbs in last months		

Do you have any **allergies** ❑ Yes ❑ No (if yes, please EXPLAIN REACTION below:)

❑	MEDICATIONS
❑	FOOD
❑	LATEX

Medications	Dose	How Often	Reason for Taking

				Amount/Day	# of Years	Quit Date
Do you smoke/use tobacco?	Yes	No	Cigarette/Pipe/Cigar			
Do you use alcohol?	Yes	No	Type:			
Recreational Drugs	Yes	No	Type:			
Do you use caffeine?	Yes	No	coffee, tea, sodas			

Family History	Mother	Father	Brothers	Sisters
Diabetes				
Heart Disease				
Stroke				
Asthma				
Cancer				
High Blood pressure				

Where is your wound located? ______________________________

How long have you had the wound? ______________________________

What medications are you using on the wound? ______________________________

What dressings are you applying to the wound? ______________________________

Do you have Home Health? ______________ Name of Agency? ______________________________

Home Health phone number: ______________________________

Height: ________________ Weight: ________________

DOMESTIC VIOLENCE

This is a common health problem in the United States. Therefore, it is our responsibility to access all patients for the presence of potential domestic violence in their lives:

Do you feel that you live in an environment safe from physical and mental abuse? ___ ❒ Yes ❒ No

Within the last year, have you been hit, slapped, kicked or otherwise hurt by someone? ❒ Yes ❒ No

Do you know where you could go or who could help, if you or someone you know are worried about domestic violence? ❒ Yes ❒ No

Nurse: Are there objective signs/behavior that might indicate current involvement in an abusive situation? ❒ Yes ❒ No

ADVANCE DIRECTIVES:

Does the patient have a Directive to Physician or Surrogates (sometimes called a Living Will)? ❒ NO

❒ Yes, **Nurse** check one of the following: ❒ On chart ❒ Asked to bring ❒ On file in Medical Records ❒ New signed

Does the patient have a Medical Power of Attorney? ❒ NO

❒ Yes, **Nurse** check on of the following: ❒ On chart ❒ Asked to bring ❒ On file in Medical Records ❒ New signed

If you answered NO to either of the above, would you like more information about Advance Directives?

❒ No ❒ Yes ❒ Verified information given

Completed by: ______________________________ Date: ________________

Review with Patient: ______________________________ Date: ________________

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