Methodist San Jacinto Methodist Hospital

Patient Information

Date: _____ Patient Name:_____ Address:_____

City:_____State:_____Zip:_____Home Phone:_____

Cell: _____ DOB:_____Age:_____ Sex:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

Relationship to Patient:_____Referring Physician:_____

Primary Care Physician:_____Nursing Home Name (If have one):_____

Pharmacy Name:_____ Location:_____

Wound History

Wound Location: _____When was it first Noticed - Date:_____

How did wound begin?_____

Has it Healed and then re-opened? Yes_____ No_____ How have you been treating wound until now?

_____

Have you had lab work completed in the last 30 days? No_____Yes_____Ordering Physician_____

Have you had circulation tests on your legs before? No_____Yes_____What facility?_____

Ordering Physician_____

What problems have you had because of your wound - such as infection, swelling other? _____

_____

Medical History - Please check all that apply.

Diabetes: Y___N____ If Yes, do you take (please check) Insulin____Oral Agents_____Byetta_____

Do you control diabetes by diet? Y_____N_____Family History: Y____N_____(Who/Age)_____

Hypertension: Y____N____Family History: Y____N_____(Who/Age)_____

Cancer: Y____N____Family History: Y____N_____(Who/Age)_____

Stroke: Y____N____Family History: Y____N_____(Who/Age)_____

Paralysis: Y____N____Family History: Y____N_____(Who/Age)_____

Phlebitis/Deep Vein Thrombosis Y____N____Family History: Y____N_____(Who/Age)_____

Miscarriage: Y____N____Family History: Y____N_____(Who/Age)_____

Heart trouble: Y____N____Family History: Y____N_____(Who/Age)_____

Rheumatoid Arthritis: Y____N____Family History: Y____N_____(Who/Age)_____

Gout: Y____N____Family History: Y____N_____(Who/Age)_____

Convulsion/ Seizures: Y____N____Family History: Y____N_____(Who/Age)_____

Lupus: Y____N____Family History: Y____N_____(Who/Age)_____

Ulcerative Colitis: Y____N____Family History: Y____N_____(Who/Age)_____

Crohn's Disease: Y____N____Family History: Y____N_____(Who/Age)_____

Scleroderma: Y____N____Family History: Y____N_____(Who/Age)_____

Hospitlization/Surgery History(Please list all past hospitalizations):

Name of Hospital	**Purpose of Hospitalization**	**Date**

Allergies: Please list all known allergies and reactions.

Allergy:_____Reaction (what happens)_____
Allergy:_____Reaction (what happens)_____
Allergy:_____Reaction (what happens)_____
Allergy:_____Reaction (what happens)_____

Medication: Please list all medications you are currently taking. Please include over the counter medications, herbal supplements and vitamins.

Medication:_____Dose:_____How Often:_____
Medication:_____Dose:_____How Often:_____
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Immunization Record

Adult Patients - 14 Years and Older - Have you received:
Tetanus Toxoid Y___N____Date:_____ Flu Shot Y____N_____Date:_____
H1N1 Y_____N_____Date:_____Pneumococcal (Pneumonia) Y_____N_____Date:_____
Children - Ages 13 and Younger - Have you received:
Tetanus Toxoid Y___N____Date:_____ Flu Shot Y____N_____Date:_____
H1N1 Y_____N_____Date:_____Other:
Pediatrician: _____Phone:_____Address:_____

Social History (Please check one for each item)

Marital Status: Single____Married____Separated____Divorced____Widowed_____
Tobacco Use: Never____Previouslly, but quit ____years ago Current ____pack(s) per day
Drug Use: Never_____Type/Frequency_____
Caffeine Use: Never____Type/Frequency_____

System Review - Please answer each area with Yes or No

Good Health Lately: Y____N____Fatique Y____N____Height:_____Weight:_____
Eyes: Glaucoma Y____N____Cataracts Y____N____
Respiratory: Chronic or frequent coughs Y____N____Spitting up blood Y____N____
Shortness of breath/sleep apnea Y____N____ Asthma/Emphysema/TB Y____N_____
Psychiatric: Depression Y____N____Claustrophobia Y____N____
Ears/Nose/Mouth/Throat: Chronic sinus problems or rhinitis Y____N____ Sore throat Y____N____
Mouth sores Y____N____Swollen glands in neck Y____N____
Gastrointestinal: Frequent diarrhea Y____N____ Constipation Y____N____Blood in stool Y____N____
Endocrine/Yepatic: Thyroid disease Y____N____Excessive thirst/urination Y____N____
Hepatitis Y____N____ **Musculoskeletal:** Joint pain Y____N____ Joint stiffness Y____N____
Weakness of muscles or joints Y____N____ Back pain Y____N____Osteoarthritis Y____N____
Genitourinary: Frequent urination Y____N____ Blood in urine Y____N____
Incontinence/dribbling Y____N____Kidney failure/dialysis Y____N____Kidney Transplant Y____N_____
Neurological: Frequent/recurring headaches Y____N____ Light headed or dizzy Y____N____
Staff Only: (abnormalities noted)
_____

Current Health Status (Please check one for each item)

Energy Level	Good _____	Fair _____	Poor _____
Physical Function	Good _____	Fair _____	Poor _____
Social Functioning	Good _____	Fair _____	Poor _____
Mental Health	Good _____	Fair _____	Poor _____
Health Perception	Good _____	Fair _____	Poor _____

Nutrition Profile (Please check Yes OR No for each item)

Difficulty chewing or swallowing? Y_____ N_____

Do you need assistance with eating? Y_____ N_____

Have you had a large weight loss? Y_____ N_____

Have you had a large weight gain? Y_____ N_____

If yes, _____pounds in _____months. Reason, if known:_____

Special diet? Y_____ N_____

Food allergies? (If yes, what_____) Y_____ N_____

Are you involved in weight loss program? Y_____ N_____

Weight loss medications:_____How many meals do you eat each day?_____

Appetite: Good_____Fair_____Poor_____Do you take nutritional supplements? Y_____N_____

How much water do you drink each day?_____8 ounce glasses

Do you exercise regularly? Y_____N_____ How often?_____

Activities of Daily Living (Please check one for each item)

Drive Automobile	_____Completely Able	_____Need Assistance	_____Not Able
Take Medications	_____Completely Able	_____Need Assistance	_____Not Able
Use Telephone	_____Completely Able	_____Need Assistance	_____Not Able
Care for Appearance	_____Completely Able	_____Need Assistance	_____Not Able
Use Toilet	_____Completely Able	_____Need Assistance	_____Not Able
Bath/Shower	_____Completely Able	_____Need Assistance	_____Not Able
Dress Self	_____Completely Able	_____Need Assistance	_____Not Able
Feed Self	_____Completely Able	_____Need Assistance	_____Not Able
Walk	_____Completely Able	_____Need Assistance	_____Not Able
Get in/Out of Bed	_____Completely Able	_____Need Assistance	_____Not Able
Housework	_____Completely Able	_____Need Assistance	_____Not Able
Prepare Meals	_____Completely Able	_____Need Assistance	_____Not Able
Handle Money	_____Completely Able	_____Need Assistance	_____Not Able
Shop for Self	_____Completely Able	_____Need Assistance	_____Not Able

Medicare (Only fill out if currently receiving Medicare)

Have you ever received a kidney transplant? N_____ Y_____ If yes, date received_____

Do you participate in a Black Lung program? N_____ Y_____ If yes, date received_____

Are services covered under a government program such as a research grant? N_____ Y_____

Are you entitled to any Veteran's Administration (VA) benefits? N_____Y_____

Authorizations

Patient Signature:_____Date:_____

(Or Legal Guardian/Power of Attorney)

Staff/Nurse Signature:_____Date:_____