St. Bernards®
WOUND HEALING

Patient Name: ______________________ MRN: ______________

O Patient / Caregiver Unable to Provide History

CHIEF COMPLAINT:

HPI: (location / quality / severity / duration / timing / context / modifying factors)

ALLERGIES: O No Known Allergy

REVIEW OF SYMPTOMS/COMPLAINTS:

Constitutional:

Yes	No	
O	O	Fatigue
O	O	Fever
O	O	Chills
O	O	Night Sweats
O	O	Marked Weight Change
O	O	Loss of Appetite

OTHER: ----------

Eyes:

Yes	No	
O	O	Double or Blurred Vision
O	O	Excessive Tearing
O	O	Dry Eyes
O	O	Sensitivity to Light
O	O	Eye Pain

OTHER: _______ _

Ears/Nose/Mouth/Throat

Yes	No	
O	O	Hearing Loss
O	O	EarPain
O	O	Post Nasal Drip
O	O	Loss of Taste
O	O	Loss of Smell
O	O	Nose Bleeds
O	O	Dental Problems
O	O	Bleeding Gums
O	O	Sore Throat
O	O	Hoarseness
O	O	Difficulty clearing ears
O	O	PainfuVSwollen Lymph Glands

OTHER: _______ _

Respiratory

Yes	No	
O	O	Cough
O	O	Spitting up Blood
O	O	Shortness of Breath
O	O	Wheezing
O	O	Oxygen Use

OTHER: ________ _

Cardiovascular (Central/ Peripheral)

Yes	No	
O	O	Chest Pain
O	O	Heart Palpitations
O	O	Heavy Sweating
O	O	Difficulty Breathing on Exertion
O	O	Swelling in legs
O	O	Leg Pain when Walking
O	O	Difficulty breathing when lying down

OTHER: _______ _

Gastrointestinal

Yes	No	
O	O	Bowel Incontinence
O	O	Change in Bowel Habits
O	O	Abdominal Pain
O	O	Difficulty Swallowing
O	O	Indigestion
O	O	Yellow Skin
O	O	Nausea/Vomiting/Diarrhea
O	O	Blood in Stools
O	O	Constipation
O	O	Loss of Appetite
O	O	Hemorrhoids
O	O	Acid Reflux

OTHER: ----------

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Yes No

Genitourinary

- O O Decreased Force of Stream
- O O Painful Urination
- O O Frequency
- O O Blood in Urine
- O O Urgency
- O O Incontinence

OTHER: ____________________

Musculoskeletal

- O O Backache
- O O Muscle Pain
- O O Muscle Wasting
- O O Muscle Weakness
- O O Joint Swelling
- O O Contractures

OTHER: ____________________

Integumentary

- O O Change in Hair, Skin, Nails
- O O Skin Dryness
- O O Skin Lumps/Lesions
- O O Itching
- O O Skin Rash
- O O Sun Sensitivity
- O O Hair Loss
- O O Callus/Corns
- O O Prone to Skin Tears

OTHER: ____________________

Neurologic

- O O Abnormal Gait
- O O Room Spinning/Dizziness
- O O Numbness/Loss of Sensation (Feet)
- O O Tingling
- O O Tremors
- O O Weakness
- O O Headaches
- O O Paralysis
- O O Fainting

OTHER: ____________________

Yes No

Psychiatric

- O O Anxiety
- O O Claustrophobia
- O O Sleep Problems
- O O Suicidal
- O O Memory Loss
- O O Nervous / Tension

OTHER: ____________________

Endocrine

- O O Cold Intolerance
- O O Heat Intolerance
- O O Excessive Thirst
- O O Excessive Hunger
- O O Excessive Urination

OTHER: ____________________

Hematologic / Lymphatic

- O O Bruise Easily
- O O Bleeding Tendency
- O O Swollen/Painful Glands

OTHER: ____________________

Allergic / Immunologic

- O O Hives
- O O Rhinitis
- O O Hay Fever

OTHER: ____________________

NOTES:

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FAMILY HISTORY:

O Cancer ____________ O Diabetes __________

O Heart Disease ____________________

O Hereditary Spherocytosis ___________

O Hypertension _______ O Kidney Disease ______

O Lung Disease ______ O Mental Illness ________

O Stroke _______ O Thyroid Problems ______

O Seizures ______ O Tuberculosis ______

O Other: __________________________________

MG / Maternal Grandparents	PG / Paternal Grandparents
M - Mother F - Father	S - Siblings

ADVANCE DIRECTIVE AND INSTRUCTIONS:

O Advance Directive: ________________________

O Advance Directive Materials Provided

O DO NOT RESUSCITATE

O Living Will

O Copy of Living Will Provided to Facility

O Durable Power of Attorney for Healthcare

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SOCIAL HISTORY:

Smoking Status: O Never Smoked O Former Smoker
O Smoke every day O Smoke some days OUnknown

O Marital Status______ O Occupation_________
O Children ________ O Alcohol Use _________
O Tobacco Use _______ O Caffeine Use _________
O Substance Abuse O Illicit Drug Use
O Cultural, Religious, or Language Concerns
O Unable to Care for Self ____________________
O Financial Concerns ______________________

O Suspected Abuse or Neglect
O Support Systems Lacking
O Food, Clothing, or Shelter Needs
O Transport Concerns O Object to Blood Products
O Noted misuse of patient's money, food, clothing, housing and / or denial of medical care?

NOTES: ______________________________

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PAST MEDICAL & SURGICAL HX:

MEDICAL HISTORY

CONSTITUTIONAL:

O Influenza Vaccine Current O Pneumonia Vaccine
O Tetanus Toxoid Vaccine Current O Cachexia
O Malignant Hyperthermia O Sleep Apnea
O Malnourished O Morbid Obesity
O Other: ____________________

EYES:

O Cataracts O Glaucoma
O Optic Neuritis O Retinopathy
O Other: __________________

EARS/NOSE/MOUTH/THROAT:

O Barotrauma O Sinusitis
O Tinnitus O Pharyngitis
O Dysphagia
O Other: ________________

RESPIRATORY:

O Abnormal Chest X-Ray O Aspiration
O Acute Respiratory Distress Syndrome (ARDS)
O Asthma O Chronic Bronchitis
O Chronic Obstructive Pulmonary Disease (COPD)
O Emphysema O Pneumonia
O Pneumothorax O Positive TB Test
O Pulmonary Embolus O Tuberculosis
O Upper Respiratory Infection (URI)
O Other: ______________________________

SURGICAL HISTORY

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O Myringotomy O Tube Placement
O Other: ______________________________
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O Lung Transplant
O Other: ______________________________
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MEDICAL HISTORY

CARDIOVASCULAR (Central / Peripheral):

O Coronary Artery Disease (CAD)
O Deep Vein Thrombosis (DVT)
O Myocardial Infarction (MI)
O Buerger's Disease O Congestive Heart Failure
O Vasculitis O Venous Insufficiency
O Hyperlipidemia O Hypertension
O Mitral Valve Prolapse O Murmur
O Peripheral Vascular Disease O Phlebitis
O Rheumatic Fever O Arrhythmia
O Sternal Wound Infection O Varicose Veins
O Venous Disease O Angina
O Other: ______________________

GASTROINTESTINAL (GI):

O Diverticuliti O Crohn's Disease O Cirrhosis
O Eating Disorder O Gastric Ulcers O GI Bleed
O Gastro Esop. Reflux Disease (GERD) O Hepatitis
O Peptic Ulcer Disease (PUD) O Hemorroids
O Hiatal Hernia O Pancreatitis O Colon Cancer
O Ulcerative Colitis O Radiation Proctitis
O Other: ______________________

GENITOURINARY (GU):

O Benign Prostate Hyperplasia (BPH)
O Dialysis O End Stage Renal Disease
O Hemodialysis O Kidney Disease
O Kidney Stones O Peritoneal Dialysis
O Prostatis
O Prostate Cancer O Undescended Testicle
O Radiation Cystitis O Urinary Tract Infection
O Other: ______________________

MUSCULOSKELETAL:

O Arthritis O Gout O Hip Fracture
O Osteoarthritis O Osteomyelitis
O Osteoporosis O Other Fracture
O Other: ______________________

SURGICAL HISTORY

O Coronary Artery Bypass Graft (CABG)
O Greenfield Filter O Heart Transplant
O Left Ventricular Assist Device (LVAD)
O Linton Procedure O Open Heart Surgery
O Pacemaker/Defibrillator O Stent Placement
O Peripheral Bypass Surgery O Vein Stripping
O Subfascial endoscopic perforator surgery
O Valve Replacement
O Other: ______________________

O Colectomy O Colostomy
O Ileostomy O Fistula Site
O Cholecystectomy
O Other: ______________________

O Previous OB/GYN Surgery
O Other: ______________________

O Amputation O Back Surgery
O Implanted Surgical Hardware O Joint Replacement
O Tendon/Ligament Surgery O Foot Surgery
O Other: ______________________

MEDICAL HISTORY

INTEGUMENTARY (HAIR/SKIN/NAILS):

- O Malignancy
- O Onychomycosis
- O Scleroderma
- O Alopecia
- O Fungal Infection
- O Other: ______________________

NEUROLOGICAL:

- O Amyotrophic lateral sclerosis (ALS)
- O Aphasia
- O CNS Trauma Injury
- O Head Injury / LOC
- O Hemorrhagic Stroke
- O Multiple Sclerosis
- O Transient Ischemic Attack (TIA)
- O Epilepsy
- O Stroke
- O Neuropathy
- O Receptive Aphasia
- O Other: ______________________

PSYCHIATRIC:

- O Alzheimer's
- O Dementia
- O Depression
- O Psychosis
- O Under Psychiatric Care
- O Other: ______________________

ENDOCRINE:

- O Adrenal Disease
- O Cortisone Treatment
- O Gestational Diabetes
- O Thyroid Disease
- O Type 1 Diabetes
- O Type II Diabetes
- O Other: ______________________

HEMATOLOGIC/LYMPHATIC:

- O Anemia
- O Anticoagulant Therapy
- O Lipidemia
- O Lymphadenopathy
- O Lymphedema
- O Sickle Cell Anemia
- O Other: ______________________

ALLERGIC/IMMUNOLOGIC:

- O AIDS
- O Epidermolysis Bullosa
- O HIV Positive
- O Immune Deficiency
- O Lupus
- O Pyoderma Gangrenosum
- O Raynaud's Disease
- O Rheumatoid Arthritis
- O Polyarteritis

Other: ______________________

Nurse: ______________________

Physician: ______________________

SURGICAL HISTORY

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Date: ______________________