WOUND CARE AND LIMB SALVAGE PLLC

Jan Ryszkowski, MD

HISTORY OF CURRENT WOUND(S)

What caused your wound? _____

How long have you had it? _____

What have you treated it with? _____

Are you currently taking antibiotics for your wound? ☐ Yes ☐ No

Have you had a recent X-ray, MRI, or cat scan for the wound? ☐ Yes ☐ No

When & Where? _____

What did it show? _____

What other things have you done (if anything) to help make the wound better?

_____

_____

PLEASE LIST ALL YOUR MEDICATIONS, DOSAGES, AND HOW YOU TAKE THEM:

Medication / Supplement	Dosage	How You Take It

Medication / Supplement	Dosage	How You Take It

ALLERGIES

Please list any medication, food, or other allergies: _____

_____

_____

_____

_____

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SURGICAL HISTORY

Name of Surgery	Date of Surgery	Surgeon

FAMILY HISTORY (Check all that apply)

Condition	Mother	Father	Maternal Grandparent	Paternal Grandparent	Sibling	Child
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Unknown History	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Are you married, single, divorced or separated? _____

Who lives at home with you? _____

Are you currently employed? _____ If so, what do you do for work? _____

Do you use tobacco products? _____ What kind of tobacco? _____

How many cigarettes per day? _____ How long have you used tobacco? _____

If you quit using tobacco, when did you quit? _____

Do you drink alcohol? _____ How many drinks per day? _____

Do you use any drugs? If so, which ones? _____

Do you have home health? If so, which company? _____

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NEW PATIENT MEDICAL HISTORY

Name _____ Date of Birth _____ Today's Date _____

Who referred you to us? _____

Primary Care Provider _____

Reason for Today's Visit _____

Preferred Pharmacy _____

Allergies *(please list all that apply)* _____

_____

Past Medical History (please check all that apply)

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Venous Disease/Stasis
- ☐ Lymphedema
- ☐ Lupus
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Pacemaker / Defibrillator
- ☐ Pacemaker / Defibrillator
- ☐ Blood Clots – Where? _____
- ☐ Stroke
- ☐ HIV / AIDS
- ☐ Hepatitis – What kind? _____
- ☐ Asthma
- ☐ COPD
- ☐ Seizures
- ☐ Cancer – What kind? _____
- ☐ Thyroid Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

_____