BETHESDA HEALTH
WOUND CARE AND HYPERBARIC MEDICINE PROGRAM

Bethesda Hospital East
2815 S. Seacrest Blvd.
Boynton Beach, FL 33435
(561) 737-7733 ext 85297

Bethesda Health City
10301 Hagen Ranch Road
Boynton Beach, FL 33437
(561) 374-5441

NEW PATIENT ADMISSION QUESTIONNAIRE

PATIENT NAME: ________________________________ **DOB** ______________

Phone # ____

Primary Care Physician ______________ Doctor referring you to Wound Center ____________

If your doctor did not refer you to our clinic, how did you hear about us?

____

Allergies ____

Height __________ Weight ______________ Date of last Tetanus shot ______________

Date of last Flu vaccine ________________ Date of last Pneumonia vaccine __________

Do you smoke? Y or N. If yes, how much do you smoke/day? ____________________

Are you a former smoker? Y or N. If yes, when did you quit? _______ Smoked/day? ________

Do you drink alcohol? Y or N. If yes, how many drinks per week? ____________________

Describe the location and nature of the wound(s) ____________________________

____

Have you had recent tests or X-rays performed pertaining to your wound(s)? YES or NO
If YES what test(s) was performed? ____________________________________

Where was the testing performed? ____________________________________

How long have you had this wound(s)? ____________________________________

Who has been treating this wound? ____________________________________

Is the wound(s) painful? YES or NO .

If YES, how bad is the pain on a pain scale of 1-10 with 10 being the worst? ______________

Patient Label

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Do you wear compression stockings? Y or N. Do you wear special shoes/inserts? Y or N

Are you currently being seen by a Home Health Agency or Visiting Nurse? YES or NO

If YES, what is the name of the agency? ____________________

Are you satisfied with their service? YES or NO

Primary Language: ☐ English ☐ OTHER ____________________

I prefer to learn by: ☐Verbal Instructions ☐ Written Instructions ☐ Demonstration/Hands on

Family HX :

Cancer: Mother - Y or N Type__________ Father - Y or N Type__________

Cardiac: Mother - Y or N Type__________ Father - Y or N Type__________

Circulation: Mother - Y or N Type__________ Father - Y or N Type__________

High Blood Pressure: Mother - Y or N. Father - Y or N

Diabetes: Mother - Y or N. Father - Y or N

Surgical History with date:

____

____

____

____

____

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NEW PATIENT ADMISSION QUESTIONNAIRE

Medical History

EENT

- [ ] Allergies/hay fever
- [ ] Ear abnormalities
- [ ] Eye injuries or defect
- [ ] Frequent or severe headaches
- [ ] Glaucoma or cataracts
- [ ] Hearing difficulties
- [ ] HOH
- [ ] Other (free text)

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] COPD
- [ ] Frequent or chronic cough
- [ ] Other (free text)
- [ ] Pneumonia
- [ ] Shortness of breath
- [ ] TB

Neurological

- [ ] Alzheimer's
- [ ] Dizziness or fainting spells
- [ ] Epilepsy/convulsions
- [ ] Frequent or severe headaches
- [ ] Hemiparesis
- [ ] Neuropathy
- [ ] Other (free text)
- [ ] Paralysis
- [ ] Quadraplegic
- [ ] Seizures
- [ ] spina bifida
- [ ] Spinal cord injury
- [ ] Stroke

Cardiovascular

- [ ] Atrial Fibrillation
- [ ] Blood clots
- [ ] CAD
- [ ] Chest pain or pressure
- [ ] CHF
- [ ] Heart Attack
- [ ] Heart Murmur
- [ ] High cholesterol/lipids
- [ ] Hypertension
- [ ] Other (free text)
- [ ] Pacemaker
- [ ] PAD
- [ ] Palpitation or pounding heart
- [ ] PVD
- [ ] Varicose veins
- [ ] Vasculitis

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Gastrointestinal

- ☐ Crohn's Disease
- ☐ Colon or bowel disease
- ☐ Digestive disorder
- ☐ Fecal incontinence
- ☐ Gallbladder problems
- ☐ GERD
- ☐ Hemorrhoids
- ☐ Other (free text)
- ☐ Recurring abdominal pain

Genitourinary

- ☐ BPH
- ☐ Calciphylaxis
- ☐ Dialysis
- ☐ ESRD
- ☐ Kidney or bladder disease
- ☐ Kidney or bladder stones
- ☐ Other (free text)
- ☐ Renal Disease
- ☐ STD
- ☐ Urinary incontinence

Hematological

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood abnormalities
- ☐ Blood borne disease
- ☐ Other (free text)
- ☐ Sickle Cell disease

Musculoskelatal

- ☐ Arthritis
- ☐ Back injury
- ☐ Carpal tunnel
- ☐ Charcot foot
- ☐ Foot problems
- ☐ Gout
- ☐ Neck injury
- ☐ Osteomyelitis
- ☐ Other (free text)
- ☐ Parkinson
- ☐ Rheumatoid Arthritis

Endocrine

- ☐ Diabetes
- ☐ Goiter or thyroid problems
- ☐ IDDM
- ☐ Other (free text)

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Psychological

- ☐ Alzheimer's
- ☐ Depression
- ☐ Nervous disorder
- ☐ Other (free text)
- ☐ Psychosis

Cancer

- ☐ Breast
- ☐ Chemotherapy
- ☐ Colon or bowel disease
- ☐ lung
- ☐ Other (free text)
- ☐ prostate
- ☐ Radiation Treatments
- ☐ skin

Hepatic

- ☐ ascites
- ☐ cirrhosis
- ☐ Hepatitis
- ☐ Other (free text)

Other

- ☐ Hernia
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Obesity
- ☐ Other (free text)
- ☐ Radiation Treatments
- ☐ Scleroderma
- ☐ Skin discoloration scars
- ☐ Skin rash or eczema
- ☐ Tendinitis
- ☐ Unexplained weight change

Skin

- ☐ Scleroderma
- ☐ Shingles
- ☐ Skin discoloration scars
- ☐ Skin rash or eczema

Completed by:____________________________ Date________________

Reviewed by:____________________________ Date__________ Time__________

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