THE WASHINGTON HOSPITAL
Hyperbaric Oxygen Medicine Department
General Information

Date _____

Name _____ Home Phone _____ SS# _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Age _____ Sex Male / Female

Incase of emergency, please contact:_____
Phone # _____ Address _____

Are you currently a patient of The Wound and Skin Healing Center? Yes No
Have you ever been a patient of The Wound and Skin Healing Center? Yes No
If no, please fill in the following:
What physician suggested you to visit the hyperbaric treatment center?
Name_____ Specialty_____ Phone_____
Address_____ City_____ State_____ Zip_____

Who is your primary care physician?
Name_____ Specialty_____ Phone_____
Address_____ City_____ State_____ Zip_____

May we provide information about your Hyperbaric Treatment to your primary care physician? Yes / No
Other information that may be helpful to us:
Home Health Care Choice_____ Pharmacy_____
Transportation Provided By_____ Telephone#_____

How did you learn of the Hyperbaric Treatment Center? (Please check all that apply)
□ T.V. □ Newspaper □ Physician □ Friend □ Other_____

How do you feel that you best learn? (Please check all that apply)
□ Reading □ Video □ one on one explanations □ Other_____

Please use the next few lines to write down any questions you may have. (If not enough space, may use other paper)_____
_____
_____
_____
_____
_____
_____

Patient Label

THE WASHINGTON HOSPITAL
Hyperbaric Medicine

Wound History

Wound Location? _____

When did you first notice the wound? _____

How did your wound start? _____

Has it ever healed and then re-opened? Yes / No

Does your wound prevent you from performing daily activities? Yes / No

How have you been treating your wound until now? Physician _____ Wound Center _____
Other_____

Have you had any lab work done in the last month? Yes / No Who ordered the blood work?
_____Where was the blood work drawn?_____

Have you had any other problems associated with your wound? (Please check all that apply)
□ Infection □ Swelling □ Other _____

Please check all that apply.

Medical History

	PATIENT		**FAMILY**		**EXPLAIN** (Who, Age)
Diabetes	Yes	No	Yes	No	
Hypertension	Yes	No	Yes	No	
Cancer	Yes	No	Yes	No	
Stroke	Yes	No	Yes	No	
Paralysis	Yes	No	Yes	No	
Phlebitis/Deep Vein Thrombosis	Yes	No	Yes	No	
Heart Trouble	Yes	No	Yes	No	
Rheumatoid Arthritis	Yes	No	Yes	No	
Gout	Yes	No	Yes	No	
Convulsions/Seizures	Yes	No	Yes	No	
Lupus	Yes	No	Yes	No	
Ulcerative Colitis	Yes	No	Yes	No	
Crohns Disease	Yes	No	Yes	No	
Scleroderma	Yes	No	Yes	No	
Emphysema / Black Lung	Yes	No	Yes	No	

If you are a diabetic please answer the following questions below. Please circle the appropriate response.
a. Do you take: Insulin Oral agents Diet controlled
b. How long have you know you have had diabetes? _____
c. Do you test your blood sugar every day? Yes / No If yes, how many time / day? _____
d. What are your blood sugar testing results? Breakfast_____ Lunch_____ Dinner_____Bedtime_____

Patient Label

THE WASHINGTON HOSPITAL
Hyperbaric Medicine

Medications

(Please list all medicines you are currently taking. Include over the counter, herbal supplements and vitamins)

Medication	Amount (dosage)	How often

Allergies (Please list all known allergies and reactions)

_____
_____
_____
_____

Hospitalization / Surgery History (Please give brief description)

Purpose of Hospitalization	Date

Social History

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Tobacco Use: □Yes:Type_____Amount_____□ No □ Previously: Quit_____years ago

Alcohol Use: □Yes □ No □ Rarely □ Moderate □ Daily

Recreational Drug Use: □Yes □ No □ Type / Frequency _____

Caffeine Use: □ Never □ Type / Frequency _____

Patient Label

THE WASHINGTON HOSPITAL
The Wound and Skin Healing Center
Nutrition Profile

Please circle the correct response that describes your current nutritional status.
Do you have difficulty chewing or swallowing? Yes / No
Do you need assistance with eating? Yes / No
Have you had a large weight loss or gain? Yes / No
If yes, _____ pounds in _____ months. Reason, if known _____
Do you follow a special diet? Yes / No
If yes, explain _____
Do you have food allergies? Yes / No
If yes, explain _____
Are you in a weight loss program? Yes / No
Weight loss medications: _____ How many meals do you eat? _____
Appetite: □ Good □ Fair □ Poor
Do you take nutritional supplements or a multi-vitamin? Yes / No
If yes, explain _____
How much water do you drink each day? _____ 8 ounce glasses
Do you exercise regularly? Yes / No

Current Health Status

Please place an "x" on the appropriate response.

Body Pain	□ None	□ Some	□ Severe
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

Activities of Daily Living

Please place an "x" on the appropriate response.

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 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

Immunization/Vaccination	Date Received
Tetanus Toxoid	
Flu Vaccine	
Pneumonia Vaccine	
Hepatitis B Vaccine	

Patient Label

THE WASHINGTON HOSPITAL
Hyperbaric Medicine
System Review

Place a circle around the appropriate response.

Good general health lately	Yes	No
Fatigue	Yes	No
Height _____ Weight _____		
Eyes		
Blurred or double vision	Yes	No
Glaucoma	Yes	No
Wear glasses or contacts	Yes	No
Cataracts	Yes	No
Ears / Nose / Mouth / Throat		
Hearing loss or ringing	Yes	No
Earaches	Yes	No
Chronic sinus problems or rhinitis	Yes	No
Nose bleeds	Yes	No
Sore throat or mouth sores	Yes	No
Swollen glands in neck	Yes	No
Cardiovascular		
Chest pain	Yes	No
Varicose veins	Yes	No
Swelling of feet, ankles of hand	Yes	No
Pacemaker	Yes	No
Respiratory		
Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Sleep apnea	Yes	No
Gastrointestinal		
Frequent heart burn	Yes	No
Frequent diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No

Genitourinary		
Frequent Urination	Yes	No
Blood in urine	Yes	No
Female – irregular period	Yes	No
Kidney failure	Yes	No
Dialysis	Yes	No
Musculoskeletal		
Joint Pain	Yes	No
Joint stiffness	Yes	No
Swelling in lower extremities	Yes	No
Weakness of muscles or joints	Yes	No
Back pain	Yes	No
Osteoarthritis	Yes	No
Neurological		
Frequent / recurring headaches	Yes	No
Light headed or dizzy	Yes	No
Psychiatric		
Memory loss or confusion	Yes	No
Depression	Yes	No
Claustrophobia	Yes	No
Suicide attempts	Yes	No
Endocrine / Hepatic		
Glandular or hormone problems	Yes	No
Thyroid Disease	Yes	No
Excessive thirst or urination	Yes	No
Heat of cold intolerance	Yes	No
Hepatitis	Yes	No
Hematologic / Lymphatic		
Slow to heal after cuts	Yes	No
Anemia	Yes	No
Lymphedema	Yes	No
Human Immunodeficiency Virus	Yes	No

Do you currently use a urinary catheter or colostomy bag? Yes No

If so, can you manage this device by yourself? Yes No

Have you ever had or been diagnosed with a pneumothorax (collapsed lung)? Yes No

Have you had recent dental work? Yes No

Have you had Chemotherapy in the past? Yes No When? _____

Have you ever taken any of the following medications? □ Doxorubicin (Adriamycin) □ Bleomycin □ Disulfiram (Antabuse) □ Cis- Platinum □ Mafenide Acetate (Sulfamylon)

Do you have any known ear problems? _____

Patient Label

I _____ have completed this document to the best of my knowledge and abilities. By signing below I am acknowledging that I have been given the chance to discuss my medical history with a physician.

Patient Signature _____ Date _____
(or Legal Guardian / Power of Attorney)

Please do not write below this line (staff use only)

Document reviewed with patient by:

Nurse / RT _____ Date _____

Physician _____ Date _____

Special concerns needing addressed.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Label