Wound History

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How did your wound develop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How long have you had this wound? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you been treated by a physician for this wound? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide name of physician, type of treatment received and/or any procedures performed.

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If not, how have you been caring for this wound? List dressings, ointments, bandages, etc., used.

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1. Has your wound (Select one) \_\_\_\_\_ Improved \_\_\_\_\_ Stayed the Same \_\_\_\_\_ Worsened
2. Do you experience pain from this wound? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Does this wound prevent you from performing any activities of daily living? If so please describe.

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1. Were you referred by a physician or hospital? If so please provide name. If not, please tell us how you heard about us.

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