wc.001

# Wound Care Evaluation

Integumentary Physiotherapy Clinic

Please use black or blue ink only. If requested fields are unknown, please leave blank and request assitant

| | | | |
|---|---|---|---|
| Patient Name | | Todays Date | |
| Occupation | | Problem | |

## OVERVIEW

| | | | | |
|---|---|---|---|---|
| When did problem first develop? | | years | | months |
| Developed spontaneously? | ☐ yes | ☐ no | | |
| Developed from an injury? | ☐ yes | ☐ no | | |
| Has the problem gotten... | ☐ better | ☐ worse | ☐ same | |

## MEDICAL/SOCIAL HISTORY I

| | | |
|---|---|---|
| Do you have bronchial asthma? | ☐ self | ☐ family |
| Do you have hypertension? | ☐ self | ☐ family |
| Do you have diabetes? | ☐ self | ☐ family |
| Do you have cardiac problems? | ☐ self | ☐ family |
| Do you have any circulatory problems? | ☐ self | ☐ family |
| Do you have kidney problems? | ☐ self | ☐ family |
| Have you ever received chemotherapy? | ☐ yes | ☐ no |
| Does patient use any tobaco products? | ☐ yes | ☐ no |

## SUBJECTIVE

| | | | | |
|---|---|---|---|---|
| Is pain present? | ☐ yes | ☐ no | ☐ paresthesia | ☐ anesthesia |
| Type of pain? | ☐ intermittent | ☐ constant | ☐ dull ache | ☐ sharp/burning |
| How does pain change with position? | ☐ yes | ☐ no | | |
| if yes, explain | | | | |
| Has a culture been taken? | ☐ yes | ☐ no | | |
| if yes, results | | | | |
| Have radiographs been taken? | ☐ yes | ☐ no | | |
| if yes, results | | | | |
| Any other special tests been performed? | ☐ yes | ☐ no | | |
| if yes, results | | | | |

## MEDICAL/SOCIAL HISTORY II

List medications currently taking

List operations that you've had

List any allergies

Your Signature