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Comprehensive Wound Assessment Form

Patient
Name:_____ID#:_____

The following questionnaire was designed to obtain an overall assessment of your general health, your wound, and social habits. **This information is necessary** and will provide your physician with the background data needed to make decisions and recommendations concerning your health care and ultimately, the healing of your wound. Please take your time, and ask for assistance if needed, to **completely and accurately fill out this form**. This form, with additional information gathered by the physician, will be used to set the foundation that your wound care protocol will be based on.

Where is your wound, how long has it been there, and what originally caused the wound? _____

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2. How large would you say the wound is? _____

3. Have you noticed any odor or drainage? ( ) NO ( )YES - Please describe the odor and drainage, include amount, color, bleeding and any other signs you feel are important.

_____

_____

4. Have you attempted to treat the wound yourself prior to seeking medical attention? ( )NO ( )YES - Please describe your treatment and the length of time you performed it._____

_____

5. Has another physician treated your wound? ( )NO ( )YES - For how long and with what method._____

6. Do you believe that you have abnormal sensations in your foot? ( ) NO ( )YES Please describe them._____

_____

7. Do you smoke? ( ) NO ( ) YES - How many cigarettes do you smoke daily? _____

8. Do you drink more than 2 alcoholic beverages a day? ( ) NO ( ) YES

9. Would you say that you eat a healthy diet? ( ) NO ( ) YES - What does your diet include? _____

_____

10. Do you take any vitamin or herbal supplements? ( ) NO ( ) YES - Please list them_____

11. Do you consider yourself to be over-weight? ( ) NO ( ) YES

12. What is your height and weight? _____

13. Do you consider yourself to be in good health? ( ) YES ( )NO

14. Do you keep your glucose (sugar) levels well controlled? ( ) YES ( ) NO ( ) N/A

15. What was your last glucose level, and when did you take it ( )N/A_____

16. Do you exercise? ( ) NO ( )YES - Please describe your exercise program

_____

_____

17. What is your goal of being seen by your wound care physician today? _____

_____

18. Are you prepared to follow instructions to attain that goal in the event that you will need to spend several months off of your feet, take antibiotics as instructed, perform dressing changes, come for regular visits, change your social habits and increase the monitoring of you overall health and wellness status? ( ) NO ( )YES

Patient signature:_____Date:_____