MATHER
JOHN T. MATHER MEMORIAL
HOSPITAL

WOUND TREATMENT CENTER
1895 WALT WHITMAN ROAD
MELVILLE, NY 11747
631-249-2347 • FAX 631-844-0229

PATIENT NAME: ____

ADDRESS:____
____
____

PREFERRED PHONE NUMBER:

HOME:____

CELL: ____

WORK: ____

PREFERRED PHARMACY NAME, ADDRESS AND PHONE NUMBER:

____

____
____
____

MAIL AWAY PHARMACY:

____
____

PRIMARY CARE DOCTOR NAME, ADDRESS, AND PHONE NUMBER:

____
____
____

REFERRING PHYSICIAN NAME, ADDRESS AND PHONE NUMBER:

____
____
____

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Patient Name: ___________________________________ Date of Birth: ________________

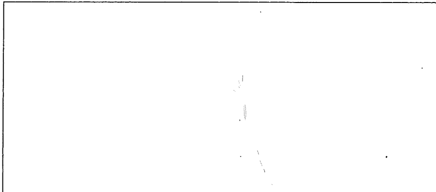
Patient/Family Self-Reported Home Medication List

Please list below any medications that you are currently taking and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

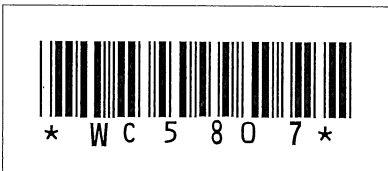
Medication	Dose	Route	Directions	Prescriber

Form Completed By: ____________________________________ Date: _________________

John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, NY 11777



PATIENT LABEL



Admission Date: ____________________ **Height:** ____________ **Weight:** ____________

❒ ***Unable to obtain a comprehensive history due to patient's condition.***

WOUND INFORMATION

How did your wound(s) start?

❒ Injury - Describe: ____________________

❒ Surgical Procedure - Describe: ____________________

❒ Appeared Gradually ❒ Other: ____________________

What treatments have been used on your wound?

❒ Whirlpool ❒ Hyperbaric Oxygen
❒ Total Contact Casting ❒ Soaks
❒ Saline Dressing ❒ Compression Wraps / Stockings
❒ Topical Gel / Ointment ❒ Other: ____________

Has your wound ever completely healed? ❒ No ❒ Yes

Has your wound healed while being treated at this Center? ❒ No ❒ Yes

Has amputation been recommended for this wound? ❒ No ❒ Yes

Have you ever been treated for a bone infection? ❒ No ❒ Yes

If Yes, *when and what treatment?* ____________________

Recent Tests or X-rays done before coming to the Wound Treatment Center? ❒ No ❒ Yes

If Yes, *type of test and when it was done:* ____________________

Do you have circulation problems in your legs? ❒ No ❒ Yes

If Yes, *have you ever had tests for circulation?* ❒ No ❒ Yes Where: ____________________ Date: __________

Immunization: When was your last tetanus shot? __________

What is your goal for seeking treatment at this Center?

SELF CARE

Can You or Do You:

Walk without assistance?	❒ No	❒ Yes	Use a cane?	❒ No	❒ Yes	Do you live alone?	❒ No	❒ Yes
Walk with assistance?	❒ No	❒ Yes	Use a brace?	❒ No	❒ Yes	Additional Comments: ____________		
Bed / Wheelchair only?	❒ No	❒ Yes	Use crutches?	❒ No	❒ Yes	____________		

Do you need help with: Shopping? ❒ No ❒ Yes Cooking? ❒ No ❒ Yes Personal Care? ❒ No ❒ Yes

SOCIAL HISTORY

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced

Language spoken at home? ❒ English ❒ Other: ____________________ Interpreter Needed? ❒ No ❒ Yes

Smoking: ❒ No ❒ Yes If Yes, How long? _____ Years How Much _____ Packs per day If quit, When: ____________

Alcohol: ❒ No ❒ Yes If Yes, Amount per Day? ____________ Type: ____________

Recreational Drugs: ❒ No ❒ Yes If Yes, Type: ____________________

Retired: ❒ No ❒ Yes If No, Employer: ____________________

Are there any Religious / Cultural Preferences that could affect your care? ❒ No ❒ Yes

If "yes" - explain:

LIST PREVIOUS SURGERIES / YEAR

____
____
____
____
____
____
____

Do you have Diabetes? ❒ No ❒ Yes
If Yes:
How long? ____________________
Do you test your blood sugar? ❒ No ❒ Yes
If Yes, how often: ____________________
What do your blood sugar results usually run? _______

Kidney Dialysis? ❒ No ❒ Yes
If Yes:
How long? __________ Frequency? __________
Days of the Week: ____________________
Shunt Location: ____________________
Shunt Type: ____________________

History of Cancer? ❒ No ❒ Yes
If Yes, Type: ____________________
Received Radiation? ❒ No ❒ Yes
If Yes, Where: ____________________
Received Chemotherapy? ❒ No ❒ Yes
If Yes, Where: ____________________

Initial History / Review of Systems

PATIENT LABEL

PAST / CURRENT MEDICAL HISTORY

☑ Check **Self** for those that you have experienced in your life or have right now and explain.

☑ Check **FH** (Family History), ***if it applies*** *to immediate family member (siblings, parents, grandparents).*

Self	FH	Cardiac / Vascular History
		Congestive Heart Failure
		Coronary Artery Disease
		Peripheral Arterial Disease
		Chest Pain / Palpitations
		High Blood Pressure
		Heart Attack
		Swelling in Legs
		Poor Circulation
		Leg Pain when Walking
		Blood Clots
		Pacemaker
Self	**FH**	**Gastrointestinal History**
		Bowel Difficulty
		Trouble Swallowing
		Reflux Disease
		Nausea / Vomiting / Diarrhea
		Inflammatory Bowel
		Celiac Disease
Self	**FH**	**Neurological History**
		Paralysis
		Tremors
		Seizure
		Stroke
		Numbness (location)
		Head / Brain Trauma
Self	**FH**	**Other Conditions**
		Diabetes
		History of Infections, bone, skin, other (MRSA/VRE/C-Diff)
		Immune Deficiency
		Lupus
		Scleroderma
		Cellulitis
		Thyroid Problems
		Jaundice / Hepatitis
Self	**FH**	**Genito Urinary**
		End Stage Renal Disease
		Incontinence (Bladder)
		Frequency
		Blood in Urine
		Other:

Self	FH	Pulmonary History
		Tobacco Use
		COPD (Chronic Obstructive Pulmonary Disease)
		Shortness of Breath
		Asthma
		Cough / Wheezing
		Tuberculosis
		Recent Lung / Virus Infection
		Oxygen use
Self	**FH**	**Musculoskeletal History**
		Broken Bones
		Leg or Foot Deformity
		Muscle Weakness/Wasting
Self	**FH**	**Prosthetics**
		Implants:
		Eye
		Breast
		Leg
		Knee Joint
		Hip Joint
		Dentures, Type:
		Other implantable devices?
Self	**FH**	**Other Conditions**
		Malnutrition
		Low Blood Count
		Anxiety / Panic / Claustrophobia
		Problems with Ears
		Eye Problems
		Cataract
		Burns
		Sickle Cell Anemia

Caregiver: ❐ No ❐ Yes **If Yes,**

Name:

Phone:

Relationship:

Additional Information: ______________________

Person Completing Form: ______________________

Signature Relationship to the Patient Date Time

Reviewed By: ______________________

RN Signature Date Time Physician Signature Date Time