VAC WOUND CARE

1186 Satellite Blvd., Suite 200, Suwanee, GA 30024
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Phone: (770) 614-6266
Fax: (678) 392-4827

Patient Questionnaire

Patient Full Name:_____ Date of Birth:_____

Address: _____ Contact Phone:_____

☐ Married ☐ Widowed ☐ SIngle

Do you have a home health agency that visits you? ☐ Yes ☐ No

Name of Agency:_____ Phone Number:_____

Person's Name from the Home Health Agency: _____

Do you have a caregiver that lives in your home with you? ☐ Yes ☐ No

Caregiver's Name:_____Phone Number:_____

Do you have any of the following conditions?

- ☐ Diabetes
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Peripheral Vascular Disease
- ☐ Other: Explain in text box

Other:

What activities are you able to do by yourself?

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Patient Questionnaire Continued

Are you a smoker? ☐ Yes ☐ No (if YES, how many cigarettes per day?)_____

Do you consume alcohol or illicit drugs? ☐ Yes ☐ No

If YES, what do you consume, how much and how often?

How often do you bathe or shower?_____

Can you drive? ☐ Yes ☐ No Do you have transportation? ☐ Yes ☐ No

How active are you?

- ☐ Very active (I can take care of all my needs by myself daily)
- ☐ moderately active (I can take care of some of my daily activities)
- ☐ Immobile (I cannot take care of any of my needs)

What kind of diet are you following? What do you regularly eat for:

Breakfast:

Lunch:

Dinner:

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Pre-Treatment Questionnaire

How long have you had the wound(s) and how long without progress or change?

What concerns you about your wounds?

What concerns you about your day to day living?

In what areas do you need help?

What caused the initial wounding event? Did the wound occur suddenly (Trauma, insect bite) or gradually develop over time (neuropathic foot ulcer, venous leg ulcer)?

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Details about the wound

Is this the first wound at this location or a recurrent wound or pattern of wounding?

Is the wound painful, and if so, what is the character and nature of the pain?

What causes the wound to get better or worse (precipitating or ameliorating factors)?

Has the patient has chills, fever, or night sweats?

Is there any history of unusual environmental or occupational exposures? Recent travel?

Does the patient have a known underlying disease (diabetes mellitus, collagen vascular disease, peripheral arterial occlusive disease, or chronic venous insufficiency), which will be evaluated in more detail during the patient assessment section?

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Description of wound

What diagnostic studies have already been completed (radiographic or nuclear medicine studies, cultures, biopsies, or vascular studies)?

What treatments have been applied (debridements, local wound cleansing and dressings, offloading and protection, compression wraps or devices to control edema, vascular [arterial or venous] surgical or radiographic interventions, hyperbaric oxygen therapy, electrical stimulation, topical growth factors, cellular or tissue-based products, or tertiary interventions)?

Has reconstructive surgery been attempted? What were the results of these interventions and were there any complications?

Appearance of wound bed/Tunneling into the wound bed:

Exudate Quantity and Quality:

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Description of wound continued

Edge of the wound and surrounding skin (periwound):

Undermining of the wound edge:

Assessment of infection:

Wound grading and classification, if applicable:

Why is the wound not healing?

An inability to heal may be due to local factors or systemic factors or both. Local factors may include:

- ☐ Repeated external trauma because of inappropriate offloading
- ☐ Foot deformity causing abnormal pressure areas
- ☐ Uncontrolled edema
- ☐ Injury from use of toxic substances
- ☐ Inappropriate measures for exudate control
- ☐ Presence of foreign bodies
- ☐ Hematoma Formation
- ☐ Undebrided wound/ necrotic or non-viable tissue
- ☐ Poor blood supply
- ☐ Hypoxia

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Patient Observations

Mental Status or Cognitive Impairment:

Pain (visual):

Position/Mobility:

Comorbidities:

Ethnicity:

Social/Family Support:

Social issues/alchohol/smoking:

Nutritional Status:

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Medical History

Medications:

Allergies:

Surgeries:

ER Visits:

Family History:

Family History:

PCP:

Last Physical: _____

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Medical History Continued

Any other specialists? If so, please give name, address, & phone number:

Notes

Any other pertinent information: