MK WOUND & LIMB SALVAGE

MEDICAL FORM

Full Name

Pharmacy **DOB:**

Home Health Agency **Long Term Care/Rehab Facitlity**

Tell us about Wounds

Where is your wound located ______________________

How long have you had the wound(s) ______________________

Describe any signs or symptoms associated with your wound (odor, numbness, drainage. etc.)

☐ Male ☐ Female

____

____

On a scale of 1-10 being the worst, how do you rate your pain? ______________________

Describe your pain by checking the boxes that apply:

- ☐ Constent (never goes away)
- ☐ Arching
- ☐ Throbbing
- ☐ Shooting
- ☐ Dull
- ☐ Cramping
- ☐ Easy to pinpoint
- ☐ Intermitten (come and goes)
- ☐ Burning)
- ☐ Stabbing
- ☐ Sharp
- ☐ Heavy
- ☐ Tender
- ☐ Difficult to pinpoint

Describe or list any conditions or activities that impact your wound, such as when walking or raising your leg: ______________________

Medical History (Please list)	Surgical History (Please list/Dates)

Allergies : ______________________ **latex :** ☐ ______________________

Food Allergies : ______________________ **Tape :** ☐ ______________________

Medication Allergies : ______________________ **Iodine:** ☐ ______________________

PHONE (316)910-0024
FAX (316)910-0023

General

______Recent weight gain; how much____
______Recent weight loss: how much____
______Fatigue
______Weakness
______Fever
______Night sweats
______Chills
______Other

EYES

______Pain
______Redness
______Loss of vision
______Double or blurred vision
______Dryness
______Blurred Vision
______Discharge/Drainage
______Excessive Tearing
______Eye Pain
______Glasses/Contacts
______Partial/Complete Blindness
______Sensitivity to light
______Vision Changes
______Other

PSYCHIATRIC

______Depression
______Excessive worries
______Difficulty falling asleep
______Difficulty staying asleep
______Difficulties with sexual
______arousal
______Poor appetite
______Other

Skin

_____Redness
_____Rash
_____Nodules/bumps
_____Hair loss
_____Color changes of hands or feet
_____Other

HEART AND LUNGS

_____ Chest pain
_____ Palpitation
_____ Shortness of breath
_____ Fainting
_____ Swollen legs or feet
_____ Cough
_____ Piaphoresis
_____ Edema
_____ Intermitten Claudication
_____ Lower extremity (leg) resting pain
_____ Lymphedema/Swelling
_____ Nocturnal dyspnea
_____ Orthopnea
_____ Syncope
_____ Other

NERVOUS SYSTEM

______Headaches
______Dizziness
______Fainting or loss of consciousness
______Numbness or tingling
______Memory loss
______ Abnormal Gate
______ Loss of sensation
_____ Seizures
_____ Spasms
_____ Syncope
_____ Tingling
_____ Tremors
_____ Weakness
_____ Other

Hematologic/Lymphatic

_____Bleeding/Clotting Disorders
_____Bleeding Tendency
_____Blood Transfusion
_____Brusing
_____Enlarged Enlarged lymph nodes
_____Swelling
_____Swollen Glands
_____Other

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EAR/NOSE/THROAT

_____Frequent sore throats
_____Hoarseness
_____Difficulty in swallowing
_____Pain in jaw
_____Bleeding Gums
_____Current Infection
_____Dental Problems
_____Difficult cleaning Ears
_____Ear Pain
_____Frequent Colds
_____Loss of smell
_____Loss of Taste
_____Nasal Congestion
_____Nose Bleeds
_____Swollen Lymph Nodes
_____Other

Integumentary (Hair/Skin/Nails)

_____Change in Hair/skin/Nails
_____Dryness
_____Calluses/Corn
_____Change in moles
_____Hemosiderin Staining
_____Itching
_____Lesions
_____Lumps
_____Open Sore
_____Prone to Skin Tears
_____Rash
_____Skin Allergies
_____Sun Sensitivity
_____Ulcers
_____Other

Endocrine

_____Cold Intolerance
_____Heat Intolerance
_____Polydypsia (Excessive Thirst)
_____Polyphagia (Excessive Hunger)
_____Polyuria (Excessive Urination)
_____Other

Musculoskeletal

_____Assistive Devices
_____Backache
_____Contractures
_____Deformities
_____Join Pain
_____Joint Swelling
_____Muscle Pain
_____Muscle Wasting
_____Muscle Weakness
_____Other

Gastrointestinal

_____Acid Reflex
_____Bloody Stools
_____Bowel Incontinence
_____Change in Bowel Habits
_____Constipation
_____Diarrhea
_____Difficulty culity Swallowing
_____Hemorrhoids
_____Indigestion
_____Jaundice
_____Loss of Appetite
_____Nausea/Vomiting
_____Rectall Bleeding
_____Stomach/abdominal pain
_____Vomiting blood
_____other

Allergic/Immunologic

_____Fequent Rashes
_____Hay Fever
_____Hives
_____Rhinitis
_____Recurrent Fevers
_____AIDS/HIV
_____Lupus
_____Pyoderma Gangrenosum
_____Rheumatoid Arthritis
_____Other

Print Name:_______________________________________ **Date:** ____________________________________

Signature:_______________________________________