



## Wound Care Intake Form

Date wound was first noticed: \_\_\_\_\_

Was it an injury: \_\_\_\_\_ Date and place of injury: \_\_\_\_\_

Any medical attention for injury/wound: \_\_\_\_\_

How have you been cleaning the wound: \_\_\_\_\_

Have you been applying a dressing: \_\_\_\_\_

What type of dressing: \_\_\_\_\_

Has any cultures been obtained: \_\_\_\_\_

Any antibiotics: \_\_\_\_\_

Any bloodwork: \_\_\_\_\_

Are you a diabetic: \_\_\_\_\_ Do you have neuropathy: \_\_\_\_\_

Recent Hg A1c: \_\_\_\_\_ Any Special diets: \_\_\_\_\_

Have you ever been diagnosed with blood flow issues: \_\_\_\_\_

Have you ever had any vascular/blood flow testing to affected area: \_\_\_\_\_

Do you smoke, consume alcohol, or use illegal substances: \_\_\_\_\_