Wound Assessment Form

Patient: _____ A&O X: _____ Phone: _____

Living Arrangement: _____ Caregiver: _____ Hrs: _____

Caregiver Name: _____ Relation: _____ Phone: _____

Patient Goals: _____

Wt _____ **Ht** _____ **Age** _____ **Temp** _____ **RR** _____ **O2%** _____ **HR** _____ **B/P** _____ **Pain: C** _____ **L** _____ **H** _____

Aching Burning Numbness Dull Sharp Stabbing Tender Throbbing Constant Intermittent Radiating Location: _____

Allergies: NKDA ☐ PCN ☐ SULF ☐ ASA ☐ IODINE ☐ CODINE ☐ MSO4 ☐ TAPE ☐ LATEX ☐

Other: _____

PMH: _____

IDDM ☐ PVD ☐ PAD ☐ CAD ☐ HTN ☐ CHF ☐ COPD ☐ HLD ☐ DEPRESSION ☐ ANXIETY ☐

DM ☐ L _____ H _____ (IC) STOOL ☐ URINE ☐ MGT: _____

Wound Type: Arterial ☐ Burn ☐ DFU ☐ PI ☐ Trauma ☐ Vascular ☐ Other: _____

Location: 1) _____ 2) _____ 3) _____

M: 1) ___ x ___ x ___ UT _____ 2) ___ x ___ x ___ UT _____ 3) ___ x ___ x ___ UT _____

Location: 4) _____ 5) _____ 6) _____

M: 4) ___ x ___ x ___ UT _____ 5) ___ x ___ x ___ UT _____ 6) ___ x ___ x ___ UT _____

Wound Care: _____

_____

PCP Name: _____ PCP Number: P _____ F _____

PCP Location: _____ Last Visit Date: _____ Next Visit: _____

Surgeon: _____ PCP Number: P _____ F _____

Last Visit Date: _____ Next Visit Date: _____

Other Physicians: _____

Orders: _____

_____

_____

Supplies / DME: _____

_____

_____