HONORHEALTH™

Date: _____

History & Physical

GENERAL INFORMATION	
PRIMARY CARE PHYSICIAN:	PHONE:
REFERRING PHYSICIAN:	PHONE:
HOME HEALTH COMPANY:	PHONE:
CARE FACILITY:	PHONE:

WOUND INFORMATION
WHERE IS YOUR WOUND?
WHEN DID YOUR WOUND START?
HOW DID YOUR WOUND START?
IS THIS A RECURRING WOUND?
PHYSICIANS THAT HAVE CARED FOR YOUR WOUND:
TYPES OF DRESSINGS USED:

SURGERIES/INVASIVE PROCEDURES

TYPE/YEAR	TYPE/YEAR
1.	5.
2.	6.
3.	7.
4.	8.

SOCIAL HISTORY

TOBACCO USE: ☐ NEVER ☐ PREVIOUS ☐ CURRENT TYPE: PACKS PER DAY: YEARS USED:

ALCOHOL USE: ☐ NEVER ☐ PREVIOUS ☐ CURRENT TYPE: DRINKS PER DAY: YEARS USED:

RECREATIONAL DRUG USE: ☐ NEVER ☐ PREVIOUS ☐ CURRENT TYPE: YEARS USED:

DO YOU LIVE ALONE? ☐ YES ☐ NO DO YOU HAVE SOMEONE AVAILABLE TO HELP YOU? ☐ YES ☐ NO

WOUND PAIN

IS YOUR WOUND PAINFUL? ☐ YES ☐ NO WHAT IS YOUR CURRENT WOUND PAIN LEVEL (0 - 10)?

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ BURNING ☐ STABBING ☐ THROBBING ☐ OTHER:

HOW IS YOUR WOUND PAIN RELIEVED? ☐ MEDICATION ☐ ELEVATION ☐ DANGLE ☐ OTHER:

Scottsdale Thompson Peak Wound Clinic
7400 E. Thompson Peak Parkway Scottsdale, AZ 85255
Phone: 480-324-7800 Fax: 480-324-7957

PATIENT LABEL

History & Physical

MEDICAL HISTORY

PLEASE INDICATE IF YOU OR ANY OF YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS:

CONDITION	PATIENT	FAMILY	EXPLAIN (WHO,AGE)
ASTHMA			
AUTOIMMUNE DISEASE TYPE:			
BLEEDING DISORDER TYPE:			
CANCER TYPE:			
CIRCULATION PROBLEMS (PVD, PAD)			
CONGESTIVE HEART FAILURE (CHF)			
CORONARY ARTERY DISEASE (CAD)			
DEEP VEIN THROMBOSIS (DVT)			
DEMENTIA			
DEPRESSION/ANXIETY			
DIABETES TYPE:			
EMPHYSEMA OR COPD			
HEPATITIS TYPE:			
HIGH BLOOD PRESSURE (HYPERTENSION)			
HIGH CHOLESTEROL (HYPERLIPIDEMIA)			
HIV/AIDS			
KIDNEY DISEASE (RENAL FAILURE)			
LYMPHEDEMA			
NEUROPATHY			
THYROID DISEASE			
RHEUMATOID ARTHRITIS			
OTHER:			

Patient Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____

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