Tri-State Memorial Hospital & Medical Campus
WOUND HEALING & HYPERBARIC MEDICINE

NEW PATIENT PACKET

PATIENT INFORMATION	Address :
First Name: M.I.:	
Last Name:	City:
SSN:	State: Zip:
DOB:	Phone/Type:
Gender: F M Marital Status: S M D W	Secondary Phone/Type:
Ethnicity/Race: □ African American □ Multi-Racial □ Asian or Pacific Islander □ Native American □ Caucasian □ Hispanic Preferred Language:	Pharmacy: Email: Primary Care Physician (PCP):

EMERGENCY CONTACT	
Emergency Contact Name:	Employed / Retired / Other
Emergency Contact Phone:	Employer Name:
Emergency Contact Address:	Employer Phone:
Relationship to Patient:	Employer Address:

CARE PROVIDERS AND INSTRUCTIONS	
Capable of Self Care: □ Yes □ No	
Caregiver: □ Yes □ No If yes, are they doing W/C?	
Agency of Caregiver:	
Caregiver Name:	
Caregiver Phone:	

ALLERGIES *(LIST ALL KNOWN ALLERGIES AND REACTIONS)*	
___ NO KNOWN ALLERGIES	MEDICATION ALLERGIES (list below):
___LATEX/RUBBER ___TAPE	
___FOOD(list):	
___OTHER:	

GENERAL HEALTH *(PLEASE EXPAND IN COMMENT SECTION)*

Do you currently have, or have had recently:	Yes	No	COMMENTS
AIDS/HIV			
Alzheimer's			
Anemia/Blood Disorder			
Arthritis *(rheumatoid/osteo)*			
Asthma/Wheezing/Emphysema			
Auto Immune Disease			
Benign Prostate Hyperplasia *(enlarged prostate)*			
Bowel Incontinence/Change in Bowel Habits/Foley/Colostomy			
Bruising/Bleeding/Clotting Disorder/Blood Thinners			
Cancer			
Chronic Obstructive Pulmonary Disease *(COPD)*			
Cirrhosis of the Liver			

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Do you currently have, or have had recently:	Yes	No	COMMENTS
Congestive Heart Failure			
Coronary Artery Disease *(CAD)*			
Cough/Coughing Up Blood/Chronic Cough			
Deep Vein Thrombosis *(clot in the vein)*			
Dementia *(loss of mental skills)*/Depression/Mental Illness			
Diabetes I or II *(juvenile or adult onset, with pregnancy)*			
Dizziness			
Edema *(swelling)*			
Fatigue *(tired all of the time)*			
Fever			
Gastro Esophageal Reflux *(GERD)*			
Glasses/Contacts/Vision Changes			
Glaucoma/Cataracts			
Head Injury			
Headache			
Hearing Loss/Aid			
Heart Disease, Myocardial Infarction *(heart attack)*			
Hyperlipidemia *(high cholesterol)*			
Hypertension *(high blood pressure)*			
Intermittent Claudication *(pain in extremities with activity)*			
Jaundice/Hepatitis/Liver Disease			
Kidney Disease/Dialysis			
Marked Weight Change/Loss of Appetite			
Nausea/Vomiting/Diarrhea			
Osteomyelitis *(bone infection)*			
Osteoporosis			
Oxygen in Use			
Paralysis			
Peripheral Vascular Disease			
Pneumonia			
Pulmonary Embolism *(blood clot in lung)*			
Pneumothorax			
Polydypsia *(excessive thirst)*			
Polyuria *(excessive urination)*			
Prone to Skin Tears			
Rash/Pruritus *(itching)*			
Seizures			
Shortness of Breath *(lying down in bed/exertion)*			
Sleep Apnea/Snoring			
Stroke			
Thyroid Disease			
Urinary Incontinence			
Weakness			

NEW PATIENT PACKET

SURGICAL HISTORY			
	Yes	No	COMMENTS
Gallbladder			
Pacemaker/Defibrillator			
Achilles Tendon Lengthening			
Back Surgery			
Foot Surgery			
Implanted Surgical Hardware			
Joint Replacement			
Ileostomy/Colostomy/Colectomy			
Stent Placement			
Valve Replacement			
Vein Stripping			
Urostomy			
Appendectomy			
Tonsillectomy			
Hysterectomy			
Other:			

Please bring medications in bottles with you to your appointment. If unable to do this, please bring a copy of your medication list.

Patient or Authorized Person Signature:_____ **Date:**_____

Printed Name of Authorized Person: _____ **Relationship to Patient** _____