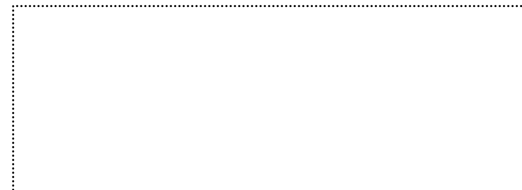
TUALITY HEALTHCARE
An OHSU Partner

Wound/Ostomy Management Services (WOMS)



Patient Name: ____ Visit Date: ____________________

Form completed by: _______________________________________ Relationship: __________________

What is the reason for your visit today?

About your wound(s):

Location:			
Duration:			
Cause:			
Associated signs/symptoms:	**Pain level?** (circle current rating) 10 Maximal 9 8 Severe 7 6 Strong 5 4 Moderate 3 2 Mild 1 0 None	**Area of pain?** (mark on the diagram below)	**Pain type?** (circle all that apply) constant comes and goes aching burning cramping dull numb pins and needles sharp shooting stabbing tender throbbing
	Pain eased by? **Pain worsened by?**		
	Drainage? (Amount, color, odor, etc.)		
	Infection? (Type of bacteria & treatment if present/known)		
	Other signs/symptoms?		
Current Treatment:			

Are you currently receiving Home Health (therapy, nursing, etc.)?	[ ] Yes	[ ] No
Do you wear any compression wrap/stocking?	[ ] Yes	[ ] No
Do you wear any customized shoe/boot?	[ ] Yes	[ ] No
Have you seen any vascular surgery specialist?	[ ] Yes	[ ] No
Have you had any vascular study of your leg(s)?	[ ] Yes	[ ] No

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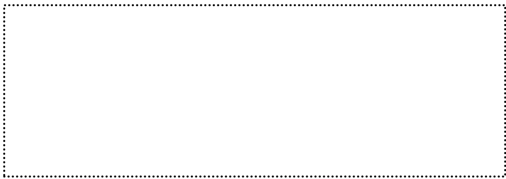

About your health:

CURRENT symptoms: (circle all that apply & draw line through if not applicable)	**General:** -Fatigue -Loss of appetite -Weight loss -Weight gain	**Ear/Eye/Nose/Mouth:** -Hearing loss/aid -Dental problems -Vision problems -Running nose	**Respiratory:** -Cough -Shortness of breath -Wheezing -Oxygen in use	**Muscles/Bones:** -Joint/muscle pain -Muscle weakness -Bone infection -Hardware in place
	Neurological: -Abnormal gait -Numbness -Weakness -Paralysis -Speech problem	**Heart/blood vessels:** -Swelling in your leg(s) and/or foot(feet) -Pain on walking -Pain in calf -Irregular heart beat	**Gastrointestinal (GI):** -Bowel incontinence -Diarrhea/loose stool -Nausea/vomiting -Colostomy/ileostomy -Constipation	**Genitourinary (GU):** -Urinary incontinence -Urinary catheter -Urostomy -Nephrostomy -On dialysis
	Hematologic: -Bleeding tendency -Clotting disorder -Bruising	**Skin/Nails:** -Itching -Rash -Calluses/corns -Fungal nail infection	**Endocrine**: -Excessive thirst -Excessive urination -Cold or heat intolerance	**Psychiatric:** -Feeling depressed -Anxious -Insomnia -Memory loss
Current medications & supplements:	Please check one of the following: [ ] I am attaching a list with all medications and supplements that I am taking. [ ] I have reviewed and updated the list provided by the clinic (WOMS) today. [ ] I have listed current medications and supplements on the backside of this page.			
Allergies: (check all that apply & list all others)	[ ] No known allergies including medications. [ ] Tapes/adhesives [ ] Latex/rubber [ ] Iodine [ ] Chlorhexidine [ ] Alcohol [ ] Metal:______________ [ ] Honey product [ ] Animal/insect: __________________ [ ] Food: ____ [ ] Medication(s): ____			

Past medical history: (circle all that apply & draw line through if not applicable)	**General:** -Tetanus vaccine -History of MRSA -Fall within past 6 months	**Ear/Eye/Nose/Mouth:** -Damage to retina -Cataracts or glaucoma -Obstructive sleep apnea	**Respiratory:** -Tuberculosis/+PPD -Pneumonia -COPD or asthma -Lung cancer	**Muscles/Bones:** -Arthritis -Gout -Hip fracture -Bone infection
	Neurological: -Stroke -TIA (mini-stroke) -Seizure/epilepsy -Parkinson's -Head injury	**Heart/blood vessels:** -Heart failure -Coronary artery disease -Blood clot -High blood pressure -Heart attack -Peripheral vascular disease -Pacemaker/defibrillator	**GI/GU:** -Crohn's disease -Irritable bowel syndrome -Hepatitis -GI bleed -Kidney disease -Enlarged prostate -Prostate cancer	**Hematologic/lymphatic:** -Anemia -Lymphedema -Leukemia **Immunologic:** -Rheumatoid arthritis -Pyoderma gangrenosum -MS -Scleroderma
	Skin/Nails: -Skin cancer -Psoriasis -Nail fungal infection -Previous wound(s)	**Endocrine:** -Diabetes (type 1 or 2) Hemoglobin A1C_____ Today's blood glucose _____________ -Diabetic ketoacidosis -Thyroid disease		**Psychiatric:** -Alzheimer's -Depression -Anxiety -Claustrophobia
Surgical history: (list including dd/mm/yy)				

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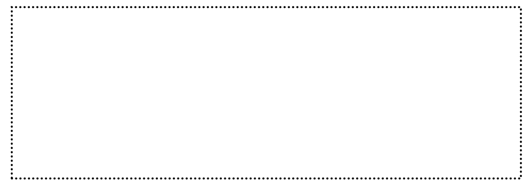

Nutrition:	Dietary restriction? [ ] No [ ] Yes (Type?) How many cups of fluid do you drink a day? ( ) Who prepares meals? ( ) How many meals and snacks per day do you eat? (Meal: Snack:) Please list any nutritional supplements you take (e.g. protein, Ensure)
Family history: (circle all that apply & list which relative)	-Diabetes -Peripheral vascular disease/poor circulation -Heart disease / high blood pressure -Other disorder
Social history:	Do you: [ ] Live alone [ ] Live with family (Who?) [ ] Live at facility (Where?)
	Do you have family and/or friend(s) who can provide help? [ ] Yes [ ] No
	Do you feel unsafe at home, at work, or at school? [ ] Yes [ ] No
	Have you been hurt by someone within the past year? [ ] Yes [ ] No
	Occupation: Retired? [ ] Yes [ ] No
	Cultural, religious, or language concerns:
	Are you concerned about paying for your treatment? [ ] Yes [ ] No Do you want to talk to anyone about finances? [ ] Yes [ ] No
	- Alcohol use: (never / previously / rarely / occasionally / daily) Amount? ________________ - Tobacco use: (never / previously / rarely / occasionally / daily) How long? ________________ - E-cig/vapor products use: (never / previously / rarely / occasionally / daily) Amt?__________ - Marijuana use: (never / previously / rarely / occasionally / daily) - Illicit drug use: (never / previously / rarely / occasionally / daily) Type:

Patient Plan of Care:

Tuality Health Wound/Ostomy Management Services (WOMS) is committed to providing you with the best care possible to heal your wound(s). However, your active participation and commitment to the treatment plan is essential for success. Please initial in each box and sign at the bottom, indicating *your commitment to your Plan of Care presented by your wound care provider and your willingness to take an active role in your healing process*:

	I will perform wound care as directed. I recognize the importance of calling WOMS with problems, questions, or concerns regarding my wound(s) or wound care.
	I will relieve or reduce pressure on my wound(s) or limit activity as recommended by my wound care provider. This may include but not limited to: bedrest, limited walking, use of special shoes/boots, insole, or offloading cast.
	I will report any signs and symptoms of infection immediately to my wound care provider. This includes but is not limited to: fever >101 °F, an increase in wound drainage, an increase in surrounding redness, an increase in pain or swelling at my wound site, and/or allergic reaction to wound dressing and/or topical agent in use.
	I agree to keep scheduled appointments to assist my wound care provider in providing the best possible care to heal my wound(s) and recognize that I may be discharged form the WOMS if not following the prescribed treatment plan.

____ ____

Patient (signature) Date Staff (signature) Date

____

Patient representative (signature) Date Relationship to the patient