Northern California Wound Care
New Patient History

Today's Date:______________________ Your Date of Birth:_________________________

First Name:________________________ Last Name: ______________________________

Email Address: ____

Address:__________________________ City:___________________________________

State:___________ Zip:__________ SSN_____________________

Primary Phone:_____________________ Secondary Phone: ______________________

Emergency Contact Name:______________________________Relationship___________

__________ Emergency Contact Phone

Number:____ Pharmacy

Name:_______________________ City:________________________________ Street:

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Primary Care Provider Name:____

History of Present Illness:

What brings you to our office today? ____

What caused it? ____ Duration

Please circle all that applies:	
Timing	Present all day every day Present Most days Comes and goes
Severity of Pain	None 1 2 3 4 5 6 7 8 9 10 Severe
Quality of Pain	Sharp Dull Throbbing Shooting Electric Other: _________

What makes the problem better: ____

What makes the problem worse: ____

Are there any factors that might delay healing:____

Do you have any allergies:____

Please circle all that applies:	
Marital Status	Single Married Divorced Widowed Number of Children:_____
Legal Documentation	Advance Directive Do Not Resuscitate Durable Power of Attorney for Healthcare Living Will
Cultural, Religious or Language Concerns:____	

Routine Medications: ____

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