

Wound Care Center

Thank you for choosing Wound Care Center as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at unhealthappalachian.org.

Dealing with non-healing wounds that are a result of trauma, surgery, complications with diabetes or pressure ulcers, often requires an aggressive multidisciplinary team approach. The Wound Care Center is dedicated to restoring health and mobility to patients living with a persistent wound and their healing rates are 23% higher than the national average.

Wound care services include pre and post-operative education, stoma marking, total contact casting, compression treatment, negative pressure wound therapy, wound irrigation and debridement, skin grafts and more.

Contact Us

Phone & Fax

Phone: (828) 262-9520

Fax: (828) 262-9524

Hours

Monday - Friday: 8:00 a.m. - 5:00 p.m.

Location

336 Deerfield Road
Boone, NC 28607



New Patient Checklist

For your first appointment, please arrive 30 minutes early and bring the following:

- Insurance Card
- Pharmacy Information
- Medical Records
- Payment
- Current Medications/Prescription Bottles
- Questions for doctor
- Photo ID
- Completed forms from this packet

_____ has an appointment with

_____ Mon. Tues. Wed. Thurs. Fri.

_____ date _____ a.m./p.m.

To reschedule your appointment, please call (828) 262-9520.

UNC
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Appalachian

unhealthappalachian.org

HDF9456 02/17/25



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

REVIEW OF SYSTEMS – Wound Care Center
Form #11976

Have you recently had the following? Please check yes or no (or leave blank if you are unsure).

<u>CONSTITUTIONAL</u>		<u>ENDOCRINE</u>	
Appetite Change	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cold intolerance	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chills	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heat intolerance	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sweats	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Fatigue/Tiredness	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Unexpected weight change	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<u>HENT</u>		<u>GENITOURINARY</u>	
Post nasal drip	<input type="checkbox"/> YES <input type="checkbox"/> NO	Difficulty urinating	<input type="checkbox"/> YES <input type="checkbox"/> NO
Trouble swallowing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Painful urination	<input type="checkbox"/> YES <input type="checkbox"/> NO
Voice change	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent urination	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Blood in urine	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>EYES</u>		<u>MUSCULOSKELETAL</u>	
Visual disturbance	<input type="checkbox"/> YES <input type="checkbox"/> NO	Back pain	
<u>RESPIRATORY</u>		<u>SKIN</u>	
Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	Color change	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wheezing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Wound	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coughing up blood	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<u>CARDIOVASCULAR</u>		<u>NEUROLOGICAL</u>	
Chest pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO
Leg swelling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lightheadedness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Palpitations	<input type="checkbox"/> YES <input type="checkbox"/> NO	Weakness	<input type="checkbox"/> YES <input type="checkbox"/> NO
Varicose veins	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<u>GASTROINTESTINAL</u>		<u>HEMATOLOGIC</u>	
Bloating	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bruises/bleeds easily	<input type="checkbox"/> YES <input type="checkbox"/> NO
Abdominal pain	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Rectal Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Constipation	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	<u>PSYCHIATRIC</u>	
Nausea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Depressed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Vomiting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervous/anxious	<input type="checkbox"/> YES <input type="checkbox"/> NO
Change in bowel habits	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Tarry (black) stools	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Heartburn	<input type="checkbox"/> YES <input type="checkbox"/> NO		

****Please let your nurse know if there are any changes in the following since your last visit: medications, preferred pharmacy, medical/surgical history, allergies, or contact information.****

Knowing more about what's going on in your life outside of our office helps us work with you to achieve your best possible health. You don't have to answer these questions, but knowing more about our patients' needs helps us learn who might benefit from more resources.

FOOD

Within the last 12 months, you worried that your food would run out before you got money to buy more.

- Never True
- Sometimes True
- Often True
- Decline to Answer

Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.

- Never True
- Sometimes True
- Often True
- Decline to Answer

HOUSING / UTILITIES

Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (ie couch surfing)?

- Yes No

Are you worried about losing your housing?

- Yes No

Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?

- Yes No

TRANSPORTATION

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- Yes No

In the past 12 months, has lack of transportation kept you from getting to meetings, work or getting things needed for daily living?

- Yes No

INTERPERSONAL SAFETY

Do you feel physically and emotionally unsafe where you currently live?

- Yes No

Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?

- Yes No

Within the past 12 months, have you been humiliated or emotionally abused by anyone?

- Yes No

Please give this page to your nurse or medical assistant once you have completed it. Thank you. We appreciate the opportunity to serve you.

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Primary Care Provider: _____

Pharmacy Name/City: _____

Medical History:			Year
A Fib	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Acid Reflux	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Blood Clotting Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Blood Transfusion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cancer What type?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Colon Polyps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
COPD/Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Crohns	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
DVT	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Fibromyalgia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Liver Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
MRSA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Organ Transplant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pulmonary Embolism (PE)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stomach Ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Thyroid Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ulcerative Colitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Varicose Veins	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Surgeries/Procedures:			Where Done	Year
Appendix	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Breast	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Bones/Joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Cataract	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Colon Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Gallbladder	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Gastric Bypass	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Heart	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Hernia Repair Type?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Prostate	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Tonsils	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Ovary	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Uterus	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Veins	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Social History: (check boxes for YES)			
Smoking	Current <input type="checkbox"/> Packs/day:	Past <input type="checkbox"/> When quit:	Never <input type="checkbox"/>
Chew/ Snuff	Current <input type="checkbox"/>	Past <input type="checkbox"/> When quit:	Never <input type="checkbox"/>
E Cigarette/ Vaping	Current <input type="checkbox"/>	Past <input type="checkbox"/> When quit:	Never <input type="checkbox"/>
Alcohol	Current <input type="checkbox"/> Drinks/week:	Past <input type="checkbox"/> When quit:	Never <input type="checkbox"/>
Drugs	Current <input type="checkbox"/> Type?:	Past <input type="checkbox"/> When quit:	Never <input type="checkbox"/>

Family History:	
Cancer	Who?:
	What type?:
	Age when diagnosed?:
Colon Polyps	Who?:
Diabetes	Who?:
Heart Disease	Who?:
Thyroid Problems	Who?:

