Wyoming Medical Center

# Patient History & Physical

Patient Label

## PATIENT HISTORY

| GENERAL INFORMATION | | | DATE: |
|---|---|---|---|
| Name: | | | Primary Phone: |
| Address: | | | Secondary Phone: |
| City: | | State: | Zip: |
| Email: | Date of Birth: | Age: | Sex: |

## ALLERGIES

❑ Yes ❑ No If yes, list: _____

_____

## EMERGENCY CONTACT INFORMATION:

| Name: | Primary Phone: |
|---|---|
| Relationship: | Secondary Phone: |

## PROVIDER INFORMATION

**Referring Provider:**

| Name: | Specialty: |
|---|---|
| | |

**Primary Provider:**

| Name: | Specialty:: |
|---|---|
| | |

**If your provider did not refer you, how did you hear about our Wound Care Center?**

❑ Self-referral ❑ Extended Care Facility (SNF, LTAC, Nursing Home) ❑ Advertising
❑ Former Patient ❑ Home Health ❑ Friend/Family
❑ Recently discharger from this hospital ❑ Recently discharged from another hospital

**Please provide contact information** (If applicable):

| Home Health Agency: | Phone: |
|---|---|
| Nursing Home/Skilled Nursing Facility: | Phone: |
| Pharmacy: | Phone: |

## PATIENT WOUND HISTORY:

| Wound Location: | | | | | | |
|---|---|---|---|---|---|---|
| When did you first notice the wound? | | | | Has it ever healed and then reopened? ❑ Yes | | ❑ No |
| How did your wound start? | ❑ Bite | ❑ Blister | ❑ Bruise | ❑ Bump | ❑ Chemical Burn | ❑ Footwear |
| | ❑ Frostbite | ❑ Gradually Appeared | | ❑ Not Known | ❑ Other Lesion | ❑ Pimple |
| | ❑ Pressure | ❑ Radiation Burn | | ❑ Surgical | ❑ Thermal Burn | ❑ Trauma |
| How have you been treating your wound until now? | | | | | | |
| Have you had any lab work done in the past month? ❑ No ❑ Yes If yes, Who ordered? | | | | | | |
| Have you ever had bacteria that resisted antibiotics? ❑ No ❑ Yes If yes, Date: | | | | | | |
| Have you ever had a bone infection? ❑ No ❑ Yes If yes, Date: | | | | | | |
| Have you had any tests done for blood flow in your legs? ❑ No ❑ Yes If yes, Date:<br>If Yes, Where was is done: _____ Who ordered: | | | | | | |
| Have you had any other problems with your wound? ❑ Infection ❑ Swelling ❑ Other: | | | | | | |

**PATIENT'S MEDICAL HISTORY** (Please check Yes or No for each item?)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Cataracts (Cloudy Vision) | | | Cirrhosis (Liver problems) | | |
| Glaucoma (Eye Disease) | | | Colitis/Crohn's (Bowel problems) | | |
| Chronic Sinus problems/congestion | | | Hepatitis: If yes, type: _____ | | |
| Middle Ear problems | | | Thyroid Disease | | |
| Ear Surgery | | | Type l Diabetes | | |
| Anemia (Tired, or low iron) | | | Type II Diabetes | | |
| Hemophilia (Bleeding disorder) | | | End Stage Renal Disease (Kidney disease) | | |
| Human Immunodeficiency Virus (HIV) | | | On Dialysis If yes, type: _____ | | |
| Lymphedema (Swelling in legs or arms) | | | Lupus (Problem with your immune system) | | |
| Sickle Cell Disease | | | Raynaud Syndrome (Problem w/blood flow (fingers or toes)) | | |
| Aspiration | | | Scleroderma (Skin disorder) | | |
| Asthma (Breathing problem) | | | Rheumatoid Arthritis (Swelling of joints) | | |
| Chronic Obstructive Pulmonary Disease (COPD) | | | History of Burn | | |
| Pneumothorax (Collapsed lung) | | | Gout (Pain in big toes) | | |
| Sleep Apnea (Stop breathing when sleeping) | | | Osteoarthritis (Pain in bones of joints) | | |
| Tuberculosis (Infection in the lungs) | | | Dementia (Memory loss that gets worse over time) | | |
| Angina (Chest Pain) | | | Neuropathy (Numbness in hands or feet) | | |
| Arrhythmia (Skipped heartbeat) | | | Paraplegia (Can't move arms or legs) | | |
| Atrial Fibrillation (Rapid heart rate) | | | Quadrapelgia (Can't move arms and legs) | | |
| Congestive heart Failure | | | Received Chemotherapy | | |
| Coronary Artery Disease (Heart Disease) | | | Surgery | | |
| Deep Vein Thrombosis (Blood clot in leg) | | | Anorexia/Bulimia | | |
| Hypertension (High blood pressure) | | | Confined Anxiety (Fear about being in a closed space) | | |
| Hypotension (Low blood pressure) | | | Peripheral Arterial Disease (Problem w/ blood flow in legs) | | |
| Myocardial Infarction (Heart attack) | | | Peripheral Venous Disease(Problem w/blood vessels in legs) | | |
| Vasculitis (Inflammation of your blood vessels) | | | Phlebitis (Inflammation in veins in your legs) | | |

**HOSPITALIZATION/SURGERY HISTORY** (Please list all)

| NAME OF HOSPITAL | REASON YOU WERE IN THE HOSPITAL | DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center for your first visit.**

Wyoming Medical Center

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**FAMILY MEDICAL HISTORY** (Please indicate with a checkmark if any of your family members have or had this condition)

| Condition | Maternal Grandparents | Paternal Grandparents | Mother | Father | Siblings |
|---|---|---|---|---|---|
| Cancer | | | | | |
| Diabetes | | | | | |
| Heart Disease | | | | | |
| Hypertension | | | | | |
| Kidney Disease | | | | | |
| Lung Disease | | | | | |
| Seizures | | | | | |
| Stroke | | | | | |
| Tuberculosis | | | | | |

**SOCIAL HISTORY:**

| | | |
|---|---|---|
| Do you live alone: ❑No ❑Yes | Do you drive: ❑No ❑Yes | Employed: ❑No ❑Yes |
| What is the highest school grade you completed: ❑1-6 ❑7-9 ❑10 ❑11 ❑12 ❑Some College ❑ College Graduate | | |
| Marital Status: ❑Married ❑Divorced ❑Separated ❑Single ❑Widowed | Spouse Name (if applicable):_____ | |
| Do you smoke: ❑No ❑Yes If yes, for how many years: _____ How many packs per day: ____ If quit, when:_____ | | |
| Do you drink alcohol: ❑No History ❑Prior History ❑Current History Type: _____ | | |
| Do you use recreational drugs: ❑No ❑Yes If yes, amount:_____ Type: _____ | | |
| Caffeine use: ❑No ❑Yes If yes, for how many years _____ How many cups per day: _____ | | |
| Financial Concerns: ❑Yes ❑No Food/Clothing/Shelter Needs: ❑Yes ❑No | | |
| Support System Intact: ❑Yes ❑No Transportations Concerns: ❑Yes ❑No | | |
| How will you travel to center: ❑Car ❑Ambulance ❑Ambulette ❑Public ❑Other: _____ | | |

**DO YOU HAVE ANY OF THE FOLLOWING?:**

| Advance Directive: ❑Yes* ❑No | Living Will: ❑Yes* ❑No | Medical Power of Attorney: ❑Yes* ❑ No | Do Not Resuscitate: ❑Yes* ❑No |
|---|---|---|---|
| *Copy required for chart | Requested by: _____ | Date: _____ | Time: _____ |
| ❑Copy Provided | Signature: _____ | Date: _____ | Time: _____ |

**ABUSE/SUICIDE RISK SCREEN:**

| | |
|---|---|
| Has anyone close to you tried to hurt or harm you recently? | ❑Yes ❑No |
| Do you feel uncomfortable with anyone in your family? | ❑Yes ❑No |
| Has anyone forced you to do things that you didn't want to do? | ❑Yes ❑No |
| Do you have any thoughts of harming yourself? | ❑Yes ❑No |

**FALLS:**

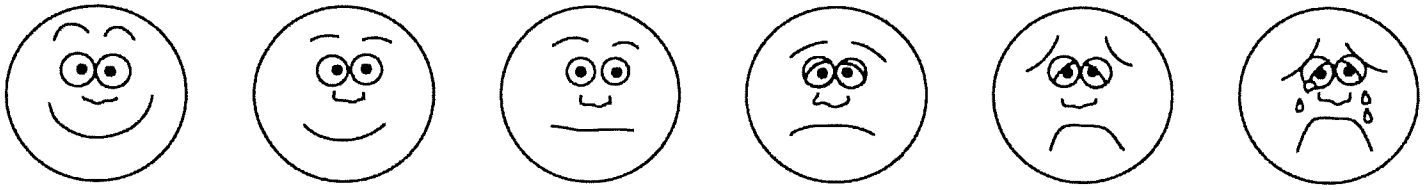
| | | |
|---|---|---|
| Have you fallen in the last 3 months? | ❑Yes | ❑No |

**NUTRITION:**

| | | |
|---|---|---|
| I have an illness or condition that made me change the kind and/or amount of food I eat: | ❑Yes | ❑No |
| I eat fewer than two meals per day: | ❑Yes | ❑No |
| I eat few fruits and vegetables, or milk products: | ❑Yes | ❑No |
| I have three or more drinks of beer, liquor or wine almost every day: | ❑Yes | ❑No |
| I have tooth or mouth problems that make it hard for me to eat: | ❑Yes | ❑No |
| I don't always have enough money to buy the food I need: | ❑Yes | ❑No |
| I eat alone most of the time: | ❑Yes | ❑No |
| Without wanting to, I have lost or gained 10 pounds in the last six months: | ❑Yes | ❑No |
| I am not always physically able to shop, cook and/or feed myself: | ❑Yes | ❑No |

**PAIN SCALE:**

How would you rate your pain using the following pain scale: ❑0 ❑2 ❑4 ❑6 ❑8 ❑10



| 0 | 2 | 4 | 6 | 8 | 10 |
|---|---|---|---|---|---|
| No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Hurts Worst |

# PATIENT SERVICES AGREEMENT

**THIS DOCUMENT SUMMARIZES THE AGREEMENT BETWEEN WYOMING MEDICAL CENTER AND EACH PATIENT WHO ACCEPTS MEDICAL CARE AND TREATMENT AT WYOMING MEDICAL CENTER FACILITIES.**

## 1. CONSENT FOR MEDICAL TREATMENT

- I understand and acknowledge that in presenting myself voluntarily for inpatient admission, emergency department treatment, or outpatient treatment, I authorize and consent to such examinations, tests, medications, photo documentation for use in the course of my care, and other medical procedures at Wyoming Medical Center as my treating physician(s) may deem necessary.
- I also understand and acknowledge that physicians who will be treating me at Wyoming Medical Center are independent contractors, which means that they are not employees or agents of Wyoming Medical Center, but are independent practitioners who will bill me separately for the services they perform. These physicians may include emergency room physicians, anesthesiologist, radiologists (who interpret X-rays or similar tests), pathologists (who perform and interpret laboratory tests), and other independent physicians who may be involved in my care.
- I also authorize such medical and nursing personnel who may be in training programs at Wyoming Medical Center to participate in my medical care.

## 2. CONSENT FOR TESTING IN THE EVENT OF AN EXPOSURE

- In the event of an accidental exposure of my blood or body fluids to another individual, I understand additional blood work may be ordered at no cost to me. Tests may include, but not limited to HIV, Hepatitis B or Hepatitis C. The WMC Employee Health Department will notify me of my test results. A letter with the test results will be sent to my home address on file if I am discharged before the results are available.

## 3. FINANCIAL AGREEMENT

- By accepting the medical services provided to me as an inpatient, outpatient, or emergency room or clinic patient, I agree to be financially responsible for the charges billed by Wyoming Medical Center for those services.
- The entire amount charged for treatment is due and payable upon receipt of the services. Wyoming Medical Center representatives can explain all credit and financial care alternatives which may be available through Wyoming Medical Center for payment of outstanding charges.
- If there is medical insurance which will cover all or a portion of the charges I incur at Wyoming Medical Center for my treatment, I hereby assign those insurance benefits to Wyoming Medical Center, and authorize the insurance benefits to be paid directly Wyoming Medical Center. Wyoming Medical Center will attempt to pre-certify all inpatient admissions with the patient's insurance carrier. However, I acknowledge that any pre-certification required by my insurance company is ultimately my responsibility.
- I understand that if my insurance benefits do not cover all of the charges for my treatment, that I am responsible to pay any outstanding balances, and that if Wyoming Medical Center is required to turn my account over to an attorney or collection agency for collection, that I will be responsible for all reasonable attorney's fees and costs of collection
- I understand that Wyoming Medical Center, its affiliates and/or agents may need to contact me for the purpose of account follow-up or collections activities. I understand and agree that communications with me may be recorded for business purposes. I expressly authorize the use of an automated telephone dialing system, or an artificial or prerecorded voice to contact my provided cell phone number, or any other number(s) provided by me, or obtained by other means available to the parties indicated above. I further expressly consent to receive communications from the parties indicated above at any phone number, email address or other unique electronic identifier or mode that I provided or was obtained on its own and not provided by me.
- If needed, I authorize Wyoming Medical Center or agent to sign any form and applications pertaining to Patient Assistance and Co-Pay Assistance Programs on my behalf.

## 4. MEDICARE PATIENTS

- I request that payment of authorized Medicare benefits be made directly to Wyoming Medical Center for any services furnished to me by Wyoming Medical Center, including its employed physicians. I authorize any holder of medical or other information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or benefits for related services.
- If you are enrolled in Medicare Part B, you may be responsible for a deductible, a 20 percent co-payment, and self-administered drug charges.

## 5. TOBACCO FREE ENVIRONMENT

- In the interest of health for all of Wyoming Medical Center's patients, staff, and visitors, Wyoming Medical Center is a tobacco-free environment. The use of Electronic Cigarettes is also prohibited.



Patient Label

# PATIENT SERVICES AGREEMENT

## 6. RELEASE OF MEDICAL INFORMATION

- I authorize Wyoming Medical Center to post patient name on personal chart, patient room, patient locator board and other procedure schedules which may be necessary for continuity of my care.
- I authorize Wyoming Medical Center to disclose medical information about my treatment including my medical condition, mental or physical condition, HIV status, alcohol / drug abuse and psychiatric diagnosis) to health insurance / benefits companies, billing companies, all attending / consulting health care providers (including those who have previously provided treatment).
- I also acknowledge that Wyoming Medical Center may be obligated to release information about my care for audit, utilization review, or accreditation purpose.

## 7. PERSONAL VALUABLES AND MEDICATIONS

- Wyoming Medical Center will not assume responsibility for lost or damaged valuables, clothing, or personal items kept in the patient's possession. Wyoming Medical Center strongly recommends that you send personal belongings home with a family member or friend. Valuables, currency, keys, wallets, credit cards, and jewelry may be deposited in the Security office for safekeeping upon patient / family request or identified need.
- Under certain circumstances, my provider may place an order allowing the staff to administer prescription medications I have brought from home. I understand that a nurse will administer my medication to me and it will not be kept at bedside. It will be locked up in the medication room or stored in the Pharmacy. All procedures specified in the Wyoming Medical Center policy related to this medication use will be followed, but I also understand that by using my own medication I am bypassing medication safety standards established by Wyoming Medical Center. I hereby release Wyoming Medical Center from any claims, damages, injuries, costs and expenses which may arise as a result of the administration of this medication, including damages for lost medications.

## 8. PATIENT ADMISSION PACKET

I acknowledge that I have been offered a copy of the Patient Admission Packet which includes:

- ✓ The Patient Services Agreement
- ✓ The Patient Rights and Responsibilities / Visitation Notice
- ✓ A Plain Language Summary of WMC's Financial Assistance Policy
- ✓ Kicking the Habit Brochure
- ✓ Suicide Prevention Brochure
- ✓ Notice of Privacy Practices Letter
- ✓ Medicare & Outpatient Services Letter

## 9. MY PATIENT PORTAL

- My Patient Portal is an interactive health record for patients of Wyoming Medical Center and the affiliated practices of Wyoming Health Medical Group LLC. All patients are automatically enrolled in this free service, unless specifically refused in writing.
- MyWMC patient portal, allows you as the patient to:
  - ✓ Communicate securely with participating health care team members
  - ✓ Request renewals of prescriptions
  - ✓ Request, review, and cancel appointments
  - ✓ View medical information including records that may be of a sensitive nature
  - ✓ View lab results, discharge summaries, and educational materials from any visit to WMC or its affiliated medical practices
- MyWMC Patient Portal is to be used only for routine matters. In the event of an emergency, call your health care provider directly, go to a nearby emergency department or urgent care center, or call 911.

I acknowledge the above information has been reviewed with me and understand the contents of this form. I have had the opportunity to ask questions which have been answered to my satisfaction. I acknowledge that I have been offered a copy of the Patient Admission Packet described in Section 8.

X _____ X _____

Patient Signature (If the patient is unable to sign, please indicate the reason.) Date/Time

_____ _____

Authorized Representative signature Relationship to patient

_____ _____

Witness Date/Time



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