

**LOCATION:** (WHERE IS YOUR WOUND LOCATED)

**ASSOCIATED SIGNS/SYMPTOMS:** DESCRIBE ANY SIGNS OR SYMPTOMS OF YOUR WOUND (SUCH AS, DRAINAGE, ODOR, NUMBNESS, ETC.)

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**TIMING:**

Yes;                    I

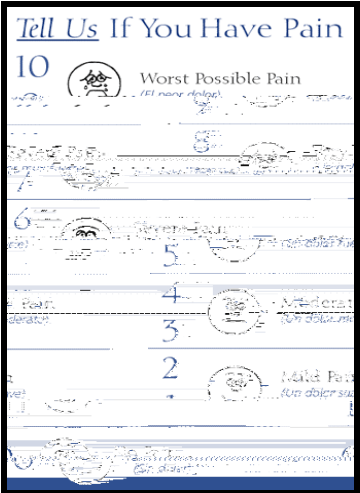
WHO ORDERED ABOVE TESTS? LAB \_\_\_\_\_ CIRCULATION: \_\_\_\_\_

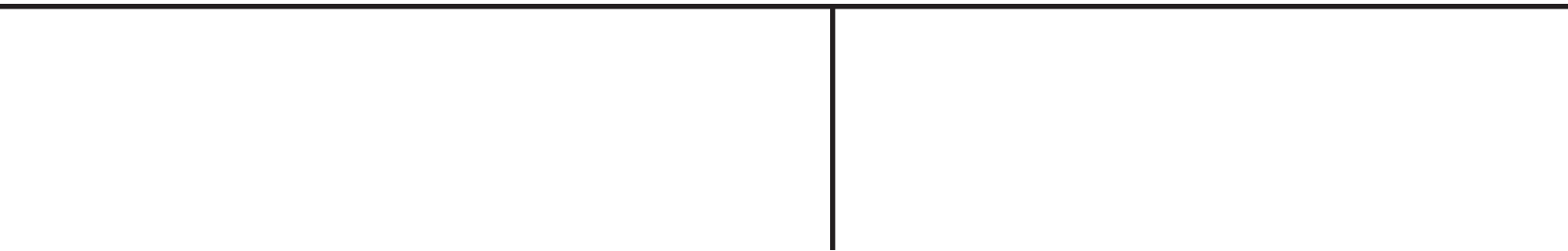
\*\* HOW HAVE YOU BEEN TAKING CARE OF YOUR WOUND?

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\*\* INFORMATION IS NOT COLLECTED IN THE CLINICAL DATABASE









Stroke			
Transient Ischemic Attack ( <i>TIA / mini-stroke</i> )			
Anxiety			
Claustrophobia			
Insomnia			
Nervousness / Tension			
Memory Loss			

**Social History**

Substance Abuse      NO      YES | DESCRIBE: