WOUND SUBJECTIVE HISTORY

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** This is a list of questions to include in your subjective history when evaluating a patient with a wound. It is not exhaustive, and other usual subjective questions such as medical and medication history should be included as well. **

Wound History

- When and how did the wound begin?
- Is there a history of other wounds, either similar or different?
- Can any other precipitating factors be associated with onset of wound?
    - Walking barefoot
    - A trip, fall, or stubbed toe
    - New shoes
    - Insect bite
    - Surgery
    - Unusual prolonged sitting, lying, standing
    - Pedicure or nail trimming
    - Dry skin, flaking, itch/scratching?
- What other signs and symptoms are present and are they improving or worsening?
    - Pain
    - Fever
    - Itching
    - Swelling
    - Drainage
- Describe the pain quality and severity. What alleviates it? What worsens it?
- Is the wound improving or worsening?
- Any allergies that may be relevant to wound treatment?
    - Analgesics
    - Antibiotics (Sulpha)
    - Antiseptics
    - Adhesives
    - Latex
    - Corticosteroids
    - Silver
    - Iodine
    - Conifer trees

Medical Diagnoses

- Many health conditions will affect wound healing.
- Does the patient have diabetes?
- Does the patient have congestive heart failure or hypertension?
- Does the patient have peripheral vascular disease?
- Any other health conditions that may affect healing ability?

Medications

- Steroids, NSAIDS, immunosuppressive medications and chemotherapy all delay wound healing.
- Other medications may affect sleep, nutrition, and glucose levels which will in turn affect wound healing
- Do they take medications as prescribed?

Symptoms

- Does the patient experience any pain?
- Is the pain at the ulcer site or in other areas?
- Assess pain using visual analog scale.
- Assess pain at the wound site and the surrounding area.
- Is there any paraesthesia or anaesthesia?
- Are symptoms relieved or worsened by elevation, rest, activity?
- What increases and decreases pain or other symptoms?

Social History

- **Occupation**: this is important so that you know how the patient spends their day with respect to limb position, weight-bearing, activity, and pressure
- **Tobacco history**: smoking, chewing
- Use of **alcohol** or **illegal drugs**
- Average amount of **sleep**
- **Daily physical activity level**: type and amount (duration or distance), offloading status if relevant
- What **type of shoes** worn most often? Inspect for pressure and wear patterns.
- **Basic nutrition**:
    - Low-carb, protein-based, plant-based, vegan, vegetarian, intermittent fasting?
    - Typical diet: sugar, fried foods, processed foods, hydration level?
    - Diet prescribed by doctor or dietician?
    - Typical number of meals/snacks per day
    - Average blood glucose levels or last A1C for patients with diabetes
    - Taking any nutritional supplements?

What Treatments have been used and what was the outcome?

- Is there any history of infection or delayed healing?
- What other healthcare professionals have been seen and when?
- What type of dressings have been used?
- How often have dressings been changed?
- How has the wound been cleaned?
- What type of offloading or assistive device has been used (if relevant) and what was the compliance level and effectiveness?
- Any use of compression stockings past or present? When last replaced? Inspect for integrity and fit.

Special Tests & Considerations

If a patient is being seen in an *acute or long-term care facility*, much of this information may be obtained from a chart review.

If seen in an *out-patient facility*, the physician referral may contain this information. If not, you may ask the patient as part of your subjective:

1. Has a wound culture been taken? What kind - was it a swab culture or a punch biopsy? What were the results?

2. Have imaging studies such as x-rays or MRI been taken to look for osteomyelitis?

3. Any other labs such as complete blood count (CBC), white blood cell count (WBC), albumin, etc.

4. What are the patient's primary concerns at this time?

5. What are the patient's top goals?

6. What does the patient see as their biggest limitation to healing?

7. How committed is the patient to making lifestyle changes? This can be asked on a 0-10 scale with 0 being not at all committed and 10 being 100% committed.