

Pre-assessment Questionnaire

Name	D.O.B.	GP	
Address		Address	
Phone no		Phone no	
Wound history		Main symptoms	
Date of onset?		Size and position of the wound	
Cause of onset? (<i>Spontaneous/trauma</i>)			
Previous diagnostic procedures	Exudate	Yes	No
	Odour	Yes	No
	Infection	Suspected	Confirmed
Previous diagnosis	Pain in situ	Yes	No
	Pain elsewhere	Yes	No
	<i>If yes - describe</i>		
Previous therapy and response	Swelling (if yes, describe)		
Supporting information (if yes, tick box)			
Hypertension		Overweight	
Heart failure/angina		Osteoarthritis	
Diabetes		Smoker	
Anaemia/polycythemia		Allergies	
Stroke or M.I.		Medication	
Malignancies		Previous surgery	

If available please enclose a photo of the wound and send, together with this form, to us at;

London Hyperbaric and Wound Healing Centres Ltd.
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