

Welcome

*Thank you for selecting our hyperbaric team!
We will strive to provide you with the best possible service.
To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.
We will be happy to help.*

to The **HYPERBARIC** Therapy Center

Patient Information

CONTINUE ONLY IF:

Not currently prescribed or taking medications:

Bleomycin, Disulfiram, Mafernade Acetate

Do not have or suspect having:

Hereditary Sperocytosis, Sickle Cell Anemia, COPD

Date: _____

Name: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Minor, Parent or Legal Guardian: _____

Spouse's Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

What Is Your Primary Reason for Coming to The Hyperbaric Therapy Center?

Who May We Thank for Referring You?

Physician Information

Are You Currently Under a Doctor's Care? Yes No

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Patient Medical History

Yes No

Yes No

1. Are you under medical treatment now?

5. Do you use alcohol?

2. Do you exercise on a regular basis?

If so, how often? _____

If so, how often? _____

6. Are you pregnant or think you may be pregnant?

3. Do you use tobacco?

If so, how many weeks? _____

If no, what was the date of your last menses period? _____

4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?

7. Are you taking any medication(s)?

If yes, please explain. _____

If yes, what medication(s) are you taking? _____

8. List any medications you are allergic to: _____

9. Do you have or have you had any of the following?

Yes No

Yes No

Yes No

Acute Respiratory Illness
AIDS or HIV Infection

Frequent Ear Infections
Frequently Tired

Mitral Valve Prolapse
Neurological Disease

Anemia

Glaucoma

Radiation Therapy

Angina

Hay Fever/Allergies

If YES, When? _____

Anxiety

Hepatitis/Jaundice

Recent Weight Loss

Arthritis

Heart Attack

Respiratory Problems

Asthma

Heart Disease

Rheumatic Fever

Back Pain

Heart Murmur

Ringing in the Ears

Cancer

Heart Problems

Rosacea

Chemical Sensitivity

Herpes

Seizure Disorders

Chest Pains

High Blood Pressure

Stomach Problems/Ulcers

Chronic Bronchitis

Infections, Frequent

Stroke

Chronic Fatigue (CFS)

Kidney Disease

Swollen Ankles

Claustrophobia

Leukemia

Thyroid Problems

Diabetes – Insulin Dependant

Liver Disease

Tuberculosis

Emphysema

Low Blood Pressure

Other: _____

Fainting / Seizures

Lung Disease

Fever Related Seizures

Lung Infection, Frequent

Fibromyalgia

Malignant Disease

Yes No

10. Have you ever had any ear problems?

11. Do you have any problems with your ears when you fly?

12. Do you have any problems going up and down in an elevator?

13. Do you have back problems?

Patient Comments:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. I understand it is my responsibility to update this information as needed. This includes changes in medical conditions / diagnosis, medications and personal and physician contact information. I agree to be responsible for payment of all services rendered on my or my dependents behalf.

Signature of patient (parent or guardian)

Doctor's Comments:

Date: _____