Welcome to The HYPERBARIC Therapy Center

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.

Patient Information

CONTINUE ONLY IF:

Not currently prescribed or taking medications:
Bleomycin, Disulfiram, Mafernide 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
1. Are you under medical treatment now?	☐	☐
2. Do you exercise on a regular basis?	☐	☐
If so, how often? _____		
3. Do you use tobacco?	☐	☐
4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain.		

	Yes	No
5. Do you use alcohol?	☐	☐
If so, how often? _____		
6. Are you pregnant or think you may be pregnant?	☐	☐
If so, how many weeks? _____		
If no, what was the date of your last minstrel period? _____		
7. Are you taking any medication(s)?	☐	☐
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	☐	☐	Frequent Ear Infections	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Frequently Tired	☐	☐	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: _____

Send This Electronically to THTC Now