NEW PATIENT INFORMATION

Hyperbaric Oxygen Therapy

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: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Circle Appropriate Box: Minor Single Married Divorced Widowed Separated

If Minor, Parent or Legal Guardian Signature: _____

Spouses Name: _____

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

Person to contact in case of Emergency: _____ Phone: _____

What is the primary reason for coming to O2 Hyperbarics? _____

_____

_____

_____

Who May we thank for Referring you? _____

Are you currently under a Doctor's Care? Yes No

Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Are you under medical treatment now? Yes No

If yes, what for: _____

_____

Do you exercise on a regular basis? Yes No How often? _____

Do you use alcohol? Yes No If so, how often? _____

Do you use tobacco? Yes No If so, how often? _____

Are you pregnant or think you may be pregnant? Yes No If so, how many weeks? _____

When was the date of your last menstrual period? _____

Have you ever been hospitalized for any reason in the past 5 years? Yes No

If so, what was the date and reason for hospitalization? _____

_____

Are you taking any medications? Yes No

If so, what medication and reason for taking? _____

_____

_____

Are you allergic to any medications? Yes No

If yes, list medication and reaction _____

_____

Do you have or had any of the following? (circle all that apply)

Acute Respiratory Illness
AIDS or HIV Infection
Anemia
Angina
Hepatitis/Jaundice
Arthritis
Asthma
Back Pain
Cancer
Chemical Sensitivity
Chest Pains
Chronic Bronchitis
Chronic Fatigue
Claustrophobia
Diabetes – insulin Dependent
Emphysema
Fainting/Seizures
Fever Related Seizures
Fibromyalgia
Frequent Ear Infections
Frequent Tired
Glaucoma
Hay Fever/Allergies
Recent Weight Loss
Heart Attack
Heart Disease
Heart Murmur
Heart Problems
Herpes
High Blood Pressure
Infections, Frequent
Kidney Disease
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Lung Infection, Frequent
Malignant Disease
Mitral Valve Prolapse
Neurological Disease
Radiation Therapy When? _____
Anxiety
Respiratory Problems
Rheumatic Fever
Ringing in the Ears
Rosacea
Seizure Disorder
Stomach Problems/Ulcers
Stroke
Swollen Ankles
Thyroid Problems
Tuberculosis
Other:
_____
_____
_____

Have you had any ear problems? Yes No

Do you have any problems with your ears when you fly? Yes No

Do you have any problems going up and down in an elevator? Yes No

Do you have back or neck problems? Yes No

Patient comments, other information you feel is important for us to know?

_____

_____

_____