HBOT INTAKE FORM

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ **Age: _____ Sex: Male ____ Female_____**

Parent's Name (if applicable):_____

Street Address:
_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell: _____ Business:_____
E-Mail Address:_____

Circle: Minor Single Married Divorced Widowed Separated

Employment: Full Time Part Time Unemployed Disabled Retired Minor

Emergency Contact: _____
Relationship to Patient: _____
Address:
_____
___
Daytime Phone: _____

Referring Physician:
_____ Phone:_____
Street Address:
_____
City: _____ State: _____ Zip:
_____

How did you hear about our facility?

_____

_____

_____

Current Health Concerns or Diagnoses (in order of priority):

1._____

2._____

3._____

4._____

5._____

6._____

7._____

PHYSICIAN:

Are you currently under a doctor's care? Yes No

Physician's Name:_____
Specialty:_____
Street Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

Do you have a prescription for hyperbaric oxygen therapy? Yes No

If yes, where? _____

SOCIAL HISTORY:

Tobacco Use: Never _____ Previously but quit _____ Current packs/day:_____

Caffeine Use: Never Frequency: _____ Source of caffeine:_____

Alcohol Use: Never Rarely Moderate Daily

Drug Use: Never Frequency: _____ Type: _____

1. **CURRENT MEDICATIONS:** (List all medicines you are currently taking including prescription and over the counter)

Medication	Dosage	Frequency

2. **ALLERGIES**: (Please list all known allergies)

_____
_____

_____
_____

3. **DIABETES**

a. Do you have diabetes? ____ Yes ____ No

b. if yes, do you take: _____Insulin _____Oral Agents _____Diet Controlled

c. How often do you test your blood sugar? _____ times/day

4. **PULMONARY/LUNG DIAGNOSIS:**

Have you ever been diagnosed with any lung/pulmonary condition, or pulmonary fibrosis?

____No ____ If Yes, what is the condition/s?
_____

5. **SEIZURE OR CONVULSION ACTIVITY**

Are you experiencing seizures or convulsions or have you been told that you are at risk for seizures?

____ No ____ Yes, please describe:
_____

6. **PREGNANCY STATUS:** Are you pregnant or think you could be? _____Yes _____ No

7. **EAR HISTORY:**

a. Have you ever had ear problems? _____Yes _____ No

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

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

d. Do you or have you ever done scuba diving? _____ Yes _____ No

8.NUTRITION PROFILE:

a. Difficulty chewing or swallowing? _____ Yes _____ No

b. Assistance needed for eating? _____ Yes _____ No

c. Have you had a large weight loss or weight gain?

____No ____Yes, _____ lbs. in _____ months

Reason if known:

d. Special diet?

_____No ____Yes, please explain
_____

e. Food allergies?
_____No _____Yes, please explain
_____

f. Are you involved in a weight loss program?
_____No _____Yes, please explain
_____

g. Appetite: _____Good _____Fair _____Poor

h. How much water do you drink each day? _____Glasses

i.Do you exercise regularly? _____Yes _____No

j. Do you take vitamins or other supplements? _____Yes ____ No

Supplements	Dosage	Frequency

Thank you for taking the time to help us better serve you.

www.OxygenRT.com