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

Patient Information

CONTINUE ONLY IF:

Not currently prescribed or taking the following medications:
Bleomycin, Disulfiram, Mafenide Acetate

Do not have or suspect having:
Hereditary Spherocytosis, Sickle Cell Anemia, COPD

*Date:*_____

*Name:*_____

Address:_____*Birth Date:*_____

*City:*_____*State:*_____*Zip Code:*_____

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

*Email Address:*_____

Check: ____Minor ____Single ____Married ____Divorced ____Separated

*If Minor, Parent or Legal Guardian:*_____

*Spouse's Name:*_____

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

*Emergency Contact:*_____*Phone:*_____

What is your primary reason for coming to Hyperbaric Oxygen Therapy of Western NY?

_____

_____

_____

*Who may we thank for referring you?*_____

Patient Medical History

	Yes	No
1. Are you under medical treatment?	___	___
2. Do you exercise regularly?	___	___
If so, how often?	_____	
3. Do you use tobacco?	___	___
4. Have you been hospitalized for any surgical operation or serious illness within the past 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, date of last menstrual period?	_____	
7. Are you taking any medications?	___	___

If yes, please list:

_____

_____

_____

8. Medication Allergies:_____

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

	Yes	No		Yes	No		Yes	No
Acute Respiratory Illness	___	___	Frequent Ear Infection	___	___	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	___	___
Chronic Bronchitis	___	___	Infections, Frequent	___	___	/Ulcers	___	___
Chronic Fatigue (CFS)	___	___	Kidney Disease	___	___	Stroke	___	___
Claustrophobia	___	___	Leukemia	___	___	Swollen Ankles	___	___
Diabetes, Insulin Dependent	___	___	Liver Disease	___	___	Thyroid Problems	___	___
Emphysema	___	___	Low Blood Pressure	___	___	Tuberculosis	___	___
Fainting / Seizures	___	___	Lung Disease	___	___	Other:		
Fever Related Seizures	___	___	Lung Infection,frequent	___	___	_____		
Fibromyalgia	___	___	Malignant Disease	___	___	_____		

10. Ear problems?_____When you fly?_____Going up and down in an elevator?_____

11. Do you have back problems?_____

Patient Comments:

_____

_____

I have accurately answered the questions above. I authorize the release of any medical information from my chart to any physician(s) who may be involved in my medical treatment. I understand it is my responsibility to update this information as needed, including changes in medical conditions / diagnoses, medications, and personal and physician contact information. I agree to be responsible for payment for all services rendered on my or my dependents behalf.

_____

Signature of patient / parent or guardian