PATIENT HISTORY FORM

Height: ____________ Weight ____________

Do you have a Caregiver/Parent for minors? Yes or No

If yes, Name of Caregiver/Parent for minors: ___________________________

Caregiver's phone we can reach them at: _____/_____/______

Do you have a Referring Physician? Yes or No

If yes: Name: ________________________________ Tel: __________________

What are you taking HBOT treatments for?: _____________________________

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Please List all Medications you are currently taking:

1. ____________________ 5. _____________________ 9.______________
2. ____________________ 6. _____________________ 10. ______________
3. ____________________ 7. _____________________ 11. ______________
4. ____________________ 8. _____________________ 12. ______________

Please list all Medications and foods you are allergic too:

1. ____________________ 5. _____________________ 8.______________
2. ____________________ 6. _____________________ 9. ______________
4. ____________________ 7. _____________________ 10. ______________

Please list past Medical History: ____