Hyperbaric Centers of Florida
21st Century technology in a safe and caring environment

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?: _____

_____

_____

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: _____