



### PATIENT INFORMATION

*The following information is very important to your health.  
Please take time to fully and completely fill out this important information.*

Full Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ LMP/? PREGNANT: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ SS# (last 4): \_\_\_\_\_

Occupation: \_\_\_\_\_

**INSURANCE/GUARANTOR:** (Responsible Party If Not You)

Insurance Company: \_\_\_\_\_

Name of Insured: (please print) \_\_\_\_\_ DOB: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**SUPPLEMENTAL INSURANCE:**

Insurance Company: \_\_\_\_\_

Name of Insured: (please print) \_\_\_\_\_ DOB: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:**

Name: \_\_\_\_\_

Practice Name/Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ May we contact regarding progress? ( ) Yes ( ) No Initial: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**REFERRAL SOURCE:**

PHYSICIAN: \_\_\_\_\_ FRIEND/RELATIVE: \_\_\_\_\_

OTHER: \_\_\_\_\_

**With whom may we share information about your care?**

Name(s): \_\_\_\_\_ Number: \_\_\_\_\_

Name(s): \_\_\_\_\_ Number: \_\_\_\_\_

## MEDICAL HISTORY QUESTIONNAIRE

**PRIMARY COMPLAINT(S):** \_\_\_\_\_

Please list your worst symptoms in order of severity/importance:

1) \_\_\_\_\_ Date first experienced: \_\_\_\_\_

2) \_\_\_\_\_ Date first experienced: \_\_\_\_\_

3) \_\_\_\_\_ Date first experienced: \_\_\_\_\_

What (if any) care did you seek in the past for the above and what was the outcome?

\_\_\_\_\_

Are you currently receiving any treatments for the above conditions? YES NO

If yes, please describe: \_\_\_\_\_

Have you ever received any hyperbaric oxygen treatments (HBOT)? YES NO

If yes - where? \_\_\_\_\_ Number of treatments: \_\_\_\_\_

**CIRCLE PAST AND CURRENT MEDICAL CONDITIONS (add others not listed in open boxes):**

Pneumothorax (collapsed lung) • COPD/Emphysema • Lung Disease • Cancer • Chemotherapy and/or Radiation treatments • High Blood Pressure • Peripheral Vascular Disease • Stroke • Diabetes • High Cholesterol • Epilepsy • Convulsions/Seizures • Coronary Artery Disease • Heart Attack • Heart Murmur • Positive Stress Test • Angina • Heart Failure • Heart Valve Abnormality • Loss of Hearing • Asthma • Pneumonia • Blood Clot in Lungs • Kidney Disease • Prostatitis • Colitis • Hepatitis • Liver Disease • Pancreatitis • Ulcer • Arthritis/Rheumatism • Loss of Consciousness • Thyroid disease • Anemia • Eczema • Sleep Apnea • Chronic Muscular Disease • Chronic Neurological Disease • HIV/AIDS


**LIST MEDICATIONS (if more space is needed, please attach list):**


**LIST ALLERGIES:** \_\_\_\_\_

**LIST ANY PAST SURGICAL PROCEDURES:**


**REVIEW OF SYSTEMS: Do you currently have or have you recently had any of the following?**

**Circle any and all that are applicable and describe in the EXPLANATION box.**

<p><b>EYES, EARS, NOSE, THROAT:</b> Difficulty with Night Vision • Change in Vision • Blurred or Double Vision • Bleeding Gums • Frequent Nose Bleeds • Frequent Sinus Trouble • Recent Hoarseness • Ringing/Buzzing Ears • Ear Aches</p>	<p><b>GASTROINTESTINAL:</b> Vomited Blood • Persistent Diarrhea • Persistent Constipation • Frequent Abdominal Pain • Frequent Nausea • Frequent Indigestion/Heartburn • Black or Bloody Bowel Movement • Hemorrhoids • Trouble Swallowing • Hernia</p>
<p><b>CENTRAL NERVOUS SYSTEM:</b> Fainting Spells • Recurrent Dizziness • Frequent Headaches • Tremors • Memory Loss • Loss of Coordination • Seizures • Numbness and or Tingling of Extremities</p>	<p><b>GENITO-URINARY:</b> Bladder Trouble • Blood in Urine • Irregular Vaginal Bleeding • Currently Pregnant • Difficulty Starting or Stopping Urination • Urinating 3 Times Per Night • Frequent or Painful Urination • Problems with Sexual Function • Infertility</p>
<p><b>PULMONARY:</b> Shortness of Breath • Chronic or Frequent Cough • Brown or Blood-Tinged Sputum • Chest Tightness • Wheezing</p>	<p><b>MENTAL HEALTH:</b> Recurrent Nightmares • Intrusive Images • Inability to Focus • Difficulty Concentrating • Anxiety • Panic Attacks • Depression • Alcohol or Drug Abuse</p>
<p><b>HEART/VASCULAR:</b> Palpitation (Irreg. Heartbeat) • Pain or Discomfort in Chest • Swelling of Feet • Leg Pain While Walking • Painful Varicose Veins</p>	<p><b>MUSCULO/SKELETAL:</b> Back Trouble/Pain • Neck Trouble/Pain • Joint Injury/Pain/Swelling • Carpal Tunnel Syndrome</p>
<p><b>MISCELLANEOUS:</b> Fever • Bleeding/Bruising Easily • Enlarged Glands • Rashes • Unexplained Lumps • Chronic Fatigue • Night Sweats • Undesired Weight Loss or Gain • Snoring • Difficulty sleeping • Low Blood Sugar</p>	<p><b>EXPLANATION:</b></p>

**DO YOU SMOKE?** YES NO - IF SO, HOW MANY PACKS PER DAY? \_\_\_\_\_

**DO YOU DRINK ALCOHOL?** YES NO - IF SO, HOW MANY DRINKS PER WEEK? \_\_\_\_\_

**DO YOU EXERCISE REGULARLY?** YES NO - IF SO, HOW MANY TIMES PER WEEK? \_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

The above information is true and correct to the best of my belief.



## CONSENT AND CONDITIONS OF TREATMENT

In consideration of the care and treatment to be provided to the patient whose name appears at the bottom of this page at Oasis Hyperbarics, you, the undersigned, consent and agree to the following conditions.

### CONSENT FOR TREATMENT

You have either been referred by your primary physician or agree to be examined by the Oasis Hyperbarics Medical Director to determine the appropriate healthcare treatment required for you. You acknowledge that you have been provided with Oasis Hyperbarics' literature on hyperbaric oxygen therapy ("HBOT") and have been provided an opportunity to ask questions. You further acknowledge that the Medical Director, or another physician or clinician, has discussed the benefits and risks of the HBOT with you and that you have received a packet of "Patient Education" information in writing.

Based upon all of the information you have received, by signing below, you are providing your voluntary, informed consent to healthcare treatment and therapeutic procedures provided by Oasis Hyperbarics and its associated physicians, clinicians, and other personnel. You are aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made as to the result of treatments or examinations.

### USE AND DISCLOSURE OF HEALTH INFORMATION

You consent to the use and disclosure of your health information for purposes of obtaining payment for services rendered to me/ the patient, treatment and health care operations (which include activities necessary to operate Oasis Hyperbarics, including without limitation conducting quality assessment and improvement activities).

\_\_\_\_\_  
DATE AND TIME

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE  
(Circle: Parent, Guardian, or Legally Authorized Representative)

\_\_\_\_\_  
WITNESS (Oasis Hyperbarics Employee)