INTERNATIONAL HYPERBARIC HEALTH CENTERS INC.

Client's Name ____
(First) (Initial) (Last)

Birth Date ____________________ Age ______________
(Y/M/D)

Mailing Address: ____

City: ____________________ Province/State: ____________________

Country: ____________________ Postal Code/Zip: ____________________

Home Phone: ( ) ______________ Business/Cell. Phone: ( ) ______________

Fax: ( ) ______________ Email: ____________________

How did you hear about us? ____________________

Have you contacted us before? ______________ Is this your first visit here? ______________

Please describe Primary Diagnosis, Medications presently taken, and concurrent therapies.

____

____

____

____

Family physician or physician aware of your condition.

Physician ______________ Clinical / Hospital ______________

Address: ____________________ Country: ______________

Postal Code: __________ Fax: ( ) __________ Email: ______________

Date of last physical examination: ____________________

Internal Use Only:	NS		Phone Book		Hood/Neck Seal	Purc/Loan			

MEDICAL HISTORY FORM

Primary Diagnosis: ____

Secondary Diagnosis: ____

Have you ever had or are you taking medication for any of the following
(Yes or No):

_______ Previous hyperbaric oxygen therapy
_______ Stroke
_______ Cancer
_______ Rheumatic condition
_______ Claustrophobia
_______ Recurring migraine headaches
_______ Decompression sickness
_______ High Blood Pressure
_______ Heart / Angina condition
_______ Dentures (removable)
_______ Asthma or wheezing with breathing
_______ Hearing Loss
_______ Problems equalizing (popping) Ears
_______ Ulcers
_______ Drug abuse (e.g. Alcohol)
_______ Hay fever (frequent or severe)
_______ Frequent colds or sinus condition
_______ Any form of lung condition
_______ Chest surgery
_______ Epilepsy, seizures, convulsions
_______ Blackouts or fainting (full/partial)
_______ Diabetes
_______ Prostheses (e.g. limbs, tooth)
_______ Angina pectoris (Heart pain)
_______ Blood vessel surgery
_______ Ear surgery
_______ Problems with balance
_______ Bleeding or other blood disorders
_______ Colostomy
_______ Smoking (e.g. tobacco)

If female, is there a possibility that you may be pregnant?____________________________
____
Do you have any allergies (e.g. Latex/ Meds)?____________________________
Have you smoked in the last 6 months?________________________________
Date and result of latest chest X-ray? ________________________________
Are you receiving any other forms of therapy?___________________________
Please elaborate on any positive response (Medications/ Surgeries):
____
____
____

A positive response to any of the above conditions means that there is a pre-existing condition that may affect your safety in receiving hyperbaric oxygen therapy. Such a condition does not necessarily disqualify you from receiving therapy when appropriate means are in place. The point of the checklist is to ensure that you are physically able to receive hyperbaric oxygen therapy in a hyperbaric chamber. Should you have any doubts about your present physical condition, you may wish to consult with your physician.

The information I have provided about my medical history is accurate to the best of my knowledge.

______________________________ ________________
Signature Date

______________________________ ________________
Print name and relationship to client Date