# Patient Intake Form


360 East 72nd Street
New York, NY 10021
(646) 719-1157
contact@mdhyperbaric.com

| TODAY'S DATE | |
|---|---|

Clear Form

## PERSONAL INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| PATIENT'S NAME | | | | | | |
| DATE OF BIRTH | | AGE | | SEX | ☐ F | ☐ M |
| PARENT'S NAME *(if applicable)* | | | | | | |
| STREET ADDRESS | | | | | | |
| CITY | | STATE | | ZIP | | |
| HOME PHONE | | CELL PHONE | | BUSINESS PHONE | | |
| E-MAIL ADDRESS | | | | | | |
| MARITAL STATUS | ☐ Minor | ☐ Single | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed |
| EMPLOYMENT | ☐ Minor | ☐ Full-time | ☐ Part-time | ☐ Unemployed | ☐ Disabled | ☐ Retired |

## EMERGENCY CONTACT

| | | | | | |
|---|---|---|---|---|---|
| NAME | | | | | |
| DAYTIME PHONE | | RELATIONSHIP TO PATIENT | | | |
| STREET ADDRESS | | | | | |
| CITY | | STATE | | ZIP | |

## REFERRAL

| | | | |
|---|---|---|---|
| HOW DID YOU HEAR ABOUT OUR FACILITY? | ☐ Friend/Family | ☐ Online | ☐ Other_____ |
| WHO CAN WE THANK FOR YOUR REFERRAL? | | | |
| E-MAIL ADDRESS | | PHONE | |

## CURRENT HEALTH CONCERNS

| | CONCERNS (PLEASE LIST IN ORDER OF PRIORITY) | PREVIOUS TREATMENT |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## PHYSICIAN

| | | | | |
|---|---|---|---|---|
| ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? | ☐ Yes | ☐ No | | |
| DID THEY RECOMMEND HYPERBARIC OXYGEN THERAPY? | ☐ Yes | ☐ No | | |
| DO YOU HAVE A PRESCRIPTION FOR HYPERBARIC OXYGEN THERAPY? | ☐ Yes | ☐ No | | |
| PHYSICIAN'S NAME | | | SPECIALTY | |
| STREET ADDRESS | | | | |
| CITY | | STATE | ZIP | |
| PHONE | | FAX | | |

## SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| TOBACCO USE | ☐ Never | ☐ Previously, but Quit | ☐ Currently | > **IF YES**, # PACKS/DAY |
| CAFFEINE USE | ☐ Never | ☐ Yes | > **IF YES**, LIST FREQUENCY & SOURCE OF CAFFEINE | |
| ALCOHOL USE | ☐ Never | ☐ Rarely | ☐ Moderately | ☐ Daily |
| DRUG USE | ☐ Never | ☐ Yes | > **IF YES**, LIST FREQUENCY & TYPE OF DRUG USE | |

## 1. CURRENT MEDICATIONS *(List all medicines you are currently taking including prescription and over-the-counter)*

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 1. CURRENT MEDICATIONS (CONTINUED)

| | | |
|---|---|---|
| | | |
| | | |

## 2. ALLERGIES *(please list all known allergies)*

| |
|---|
| |
| |

## 3. DIABETES

| | | | |
|---|---|---|---|
| DO YOU HAVE DIABETES? | ☐ Yes | ☐ No | |
| > **IF YES**, DO YOU TAKE: | ☐ insulin | ☐ oral agents | ☐ diet controlled |
| > **IF YES,** HOW OFTEN DO YOU TEST YOUR BLOOD SUGAR? | _____ time(s)/day | | |

## 4. PULMONARY LUNG DIAGNOSIS

| | | |
|---|---|---|
| HAVE YOU EVER BEEN DIAGNOSED WITH ANY LUNG / PULMONARY CONDITION, OR PULMONARY FIBROSIS? | ☐ No | ☐ Yes |
| > **IF YES,** WHAT IS THE CONDITION? | | |

## 5. SEIZURE OR CONVULSION ACTIVITY

| | | |
|---|---|---|
| ARE YOU EXPERIENCING SEIZURES OR CONVULSIONS OR HAVE YOU BEEN TOLD THAT YOU ARE AT RISK FOR SEIZURES? | ☐ No | ☐ Yes |
| > **IF YES**, WHAT IS THE CONDITION(S)? | | |

## 6. PREGNANCY STATUS

| | | |
|---|---|---|
| ARE YOU PREGNANT OR THINK YOU COULD BE? | ☐ No | ☐ Yes |

## 7. EAR HISTORY

| | | |
|---|---|---|
| **a)** HAVE YOU EVER HAD EAR PROBLEMS? | ☐ No | ☐ Yes |
| **b)** DO YOU HAVE ANY PROBLEMS WITH YOUR EARS WHEN YOU FLY? | ☐ No | ☐ Yes |
| **c)** DO YOU HAVE ANY PROBLEMS GOING UP AND DOWN IN AN ELEVATOR? | ☐ No | ☐ Yes |
| **d)** DO YOU OR HAVE YOU EVER DONE SCUBA DIVING? | ☐ No | ☐ Yes |
| **d)** DO YOU KNOW HOW TO EQUALIZE PRESSURE IN YOUR EARS? | ☐ No | ☐ Yes |

## 8. MEDICAL IMPLANTS

| | | |
|---|---|---|
| DO YOU HAVE ANY IMPLANTED MEDICAL DEVICES? | ☐ No | ☐ Yes |
| **> IF YES**, PLEASE DESCRIBE THE DEVICE, MANUFACTURER AND DATE IMPLANTED. | | |

## 9. NUTRITION PROFILE

| | | |
|---|---|---|
| **a)** DO YOU HAVE DIFFICULTY CHEWING OR SWALLOWING? | ☐ No | ☐ Yes |
| **b)** DO YOU NEED ASSISTANCE FOR EATING? | ☐ No | ☐ Yes |
| **c)** HAVE YOU HAD A LARGE WEIGHT LOSS OR WEIGHT GAIN? | ☐ No | ☐ Yes |
| **> IF YES**: _____ lbs. _____ months | | |
| **> IF YES**, REASON (IF KNOWN): | | |
| **d)** DO YOU HAVE A SPECIAL DIET? | ☐ No | ☐ Yes |
| **> IF YES**, PLEASE EXPLAIN: | | |
| **e)** DO YOU HAVE ANY FOOD ALLERGIES OR SENSITIVITIES? | ☐ No | ☐ Yes |
| **> IF YES**, PLEASE EXPLAIN: | | |
| **f)** ARE YOU INVOLVED IN A WEIGHT LOSS PROGRAM? | ☐ No | ☐ Yes |
| **> IF YES**, PLEASE EXPLAIN: | | |
| **g)** HOW IS YOUR APPETITE? | ☐ Good ☐ Fair ☐ Poor | |
| **h)** HOW MUCH WATER DO YOU DRINK EACH DAY? | _____glasses | |
| **i)** DO YOU EXERCISE REGULARLY? | ☐ No | ☐ Yes |
| **j)** DO YOU TAKE VITAMINS OR SUPPLEMENTS | ☐ No | ☐ Yes |

**> IF YES**, LIST ALL VITAMINS AND/OR SUPPLEMENTS TAKEN.

| SUPPLEMENT | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
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| | | |