WOUND CARE and HYPERBARICS

Vital Signs
BP: _____
HR: _____
Temp: _____
R: _____

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? Yes _____ No _____ Date of next physician's visit: _____

Do you have, or have you had any of the following?

	Yes	No	Family
Diabetes			
Chest Pain			
High Blood Pressure			
Heart Disease			
Heart Attack			
Stroke/CVA			
Heart Palpitations			
Pacemaker			
Headaches			
Kidney Problems			
Seizures			
Cancer			
Osteoporosis			
Bowel/Bladder Abnormalities			
Urine Leakage			
Blood Virus (HIV/AIDS/Hep C)			
Asthma/Breathing Difficulties			
Liver/Gallbladder Problems			
Optic Neuritis/Eye Disorders			
COPD/Emphysema/Lung Issues			
Blood Clotting Disorder/DVT			
Lymphedema			

	Yes	No
Allergies to Medications		
Allergies to Environment		
Other Allergies		
Taking Blood Thinners?		
Hernia		
Are you pregnant?		
Metal Implants		
Dizziness/Fainting		
Recent Fracture		
Surgeries (List below)		
Skin Abnormalities		
Sexual Dysfunction		
Nausea/Vomiting		
Sinus Problems		
Ringing in your ears		
Rheumatoid Arthritis		
Special Diet Guidelines		
Hypoglycemia (Low sugar)		
Smoking		
Recent cardiologist work up?		
Other		

If you answered yes to any of the above, please briefly explain and give approximate dates: _____

_____

_____

_____

_____

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Is there any other information regarding your past medical history that we should know about? _____

_____

_____

_____

List any current medications and dosage. _____

_____

_____

_____

_____

Patient agrees for medication retrieval inquiry: Yes _____ No _____

What is your preferred pharmacy?

Name: _____

Address: _____

Phone: _____ Fax number: _____

Do you use tobacco? Yes _____ No _____ If yes, what form? _____

Do you have a Do Not Resuscitate (DNR) order in place? Yes _____ No _____

Patient's Signature _____ Date: _____

Signature of Guardian: _____ Date: _____
(if patient is a minor)