

**Hyperbaric Services of the Palm Beaches, LLC**  
**5130 Linton Blvd., Suite H3 & 4**  
**Delray Beach, FL 33484**  
**561-819-6125 Fax 561-819-6127 800-983-8582**

**Patient Medical History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

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

|                       | YES | NO |                           | YES | NO |                       | YES | NO |
|-----------------------|-----|----|---------------------------|-----|----|-----------------------|-----|----|
| Aids or HIV Infection | —   | —  | Glaucoma                  | —   | —  | Malignant Disease     | —   | —  |
| Anemia                | —   | —  | Hay Fever/Allergies       | —   | —  | Mitral Value Prolapse | —   | —  |
| Angina                | —   | —  | Hepatitis/Jaundice        | —   | —  | Neurological Disease  | —   | —  |
| Arthritis             | —   | —  | Heart Attack              | —   | —  | Radiation Therapy     | —   | —  |
| Asthma                | —   | —  | Heart Disease             | —   | —  | Recent Weight Loss    | —   | —  |
| Bronchitis            | —   | —  | Heart Murmur              | —   | —  | Respiratory Problems  | —   | —  |
| Cancer                | —   | —  | Heart Problems            | —   | —  | Rheumatic Fever       | —   | —  |
| Cardiac Pacemaker     | —   | —  | Herpes                    | —   | —  | Rosacea               | —   | —  |
| Chest Pains           | —   | —  | High Blood Pressure       | —   | —  | Seizure Disorders     | —   | —  |
| Claustrophobia        | —   | —  | Infections, Frequent      | —   | —  | Stomach Problems      | —   | —  |
| Cough - Chronic       | —   | —  | Joint Replacement/Implant | —   | —  | Stroke                | —   | —  |
| Diabetes              | —   | —  | Kidney Disease            | —   | —  | Swollen Ankles        | —   | —  |
| Ear Problems/Surgery  | —   | —  | Liver Disease             | —   | —  | Thoracic Surgery      | —   | —  |
| Emphysema             | —   | —  | Low Blood Pressure        | —   | —  | Tuberculosis          | —   | —  |
| Epilepsy/Convulsions  | —   | —  | Lung Disease              | —   | —  | Ulcer                 | —   | —  |
| Fainting/Seizures     | —   | —  | Lung Infection, Frequent  | —   | —  | Wounds                | —   | —  |
| Frequently Tired      | —   | —  | Lung, Shortness of Breath | —   | —  | Other                 | —   | —  |

If yes, notes or comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List of surgical procedures (procedure and date): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies to Medications: (List) \_\_\_\_\_

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List of Current Medications: \_\_\_\_\_

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I certify that I have read and understand the above information to the best of my Knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in medical treatment. I authorize Hyperbaric Services of the Palm Beaches, LLC to use photographs of me in education presentations. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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Signature of patient (parent or guardian)

Date