OXYGENOASIS
A Center for Healing

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 & result of latest chest X-ray?_____
Are you now 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