ATXHyperbaricsO_2

5656 Bee Caves Road, Suite C-103
West Lake Hills, TX 78746
512.953.9421
Westlake@ATXHyperbarics.com

Full Name: ______________________________________ Date: _____/_____/______

Date of Birth: _____/_____/______ Age: ___________ ☐ Male ☐ Female

Address: ________________________ City: ________________________ State: _______

Zip Code: _______________ E-mail address_____________________________________

Phone #: (_______)_______________ Alt. Phone #: (_______)_________________

Employer: ____________________________ Occupation: _______________________

Emergency Contact Name, Relation, & Phone Number: ___________________________

How did you hear about us?: ____

Known Allergies (Food, Drugs, Vaccines, or Environmental):

____

Current Health Concerns (Please list in order of priority):

1) ____

2) ____

3) ____

4) ____

5) ____

6)____

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Current Medications (Prescription, Over the Counter Drugs, Vitamins, Herbs, Homeopathic Remedies, Etc.)

1) _______________ Dosage __________

2) _______________ Dosage __________

3) _______________ Dosage __________

4) _______________ Dosage __________

5) _______________ Dosage __________

6) _______________ Dosage __________

7) _______________ Dosage __________

8) _______________ Dosage __________

9) _______________ Dosage __________

10) ______________ Dosage __________

PLEASE ANSWER THE FOLLOWING QUESTIONS ON YOUR PAST OR PRESENT MEDICAL HISTORY WITH YES OR NO. **If you are not sure, answer YES**

Could you be pregnant, or are you attempting to become pregnant? __________

Have you ever had or do you currently have...

________ Lung disease, any form

________ Emphysema

________ Epilepsy/Seizures

________ Diabetes

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________ Pneumothorax/Collapsed Lung

________ Cataracts

________ Chest surgery

________ Heart Failure

________ Heart Disease

________ High Blood Pressure

________ Any diseases or conditions involving ears or sinus or surgical interventions

________ Difficulty in clearing ears during airplanes or pressurized environments like diving

________ Claustrophobia

Are you presently taking prescription medications for any of the above questions? If so, please specify:

____

____

____

The information I have provided is true and accurate to the best of my knowledge, and I have been explained the potential risks for any of the above questions that I answered “yes” to and have been given the opportunity to speak to my doctor or a health care provider about this.

Signature: ______________________________________ Date: _____/_____/______