BAROMEDICAL ASSOCIATES, LLC
Hyperbaric Oxygen Therapy

MEETING THE CHALLENGE OF LIVING WELL

Please check your clinic preference:

Willow Bend HBO 2633 Pkwy #200 Plano, TX 75093 (972) 403-0403	Texas Sports Hyperbarics 6901 Snider Plza #150 Dallas, TX 75205 (214) 389-6475	Global Generations HBO Kiddo2s Pediatric HBO 3716 Standridge Dr. #202 The Colony, TX 75056 (972) 403-0403	BaroMed HBO 456 State Hwy 121 bldg. 2, #140 Coppell, TX 75019 (972) 403-7784
☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Please complete this form and return it to us prior to your scheduled appointment.

Patient Name: _____ ❑ Male ❑ Female

Date of Birth: _____ **Insurance:** _____ **ID#:** _____

Address: _____ **City** _____ **State** **Zip** _____

Daytime Phone: _____ **Cell phone:** _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Referred By: _____ **Pref Language:** _____

Condition being treated: _____

Symptoms: _____

_____

_____

_____

_____

_____

_____

_____

Patient Medical History (Check any past/current problems)**:**

- ❑ Confused
- ❑ Unresponsive
- ❑ Eyes
- ❑ Ears
- ❑ Nose
- ❑ Mouth
- ❑ Sinus
- ❑ Throat
- ❑ Skin Problem
- ❑ Rash
- ❑ Hives
- ❑ Hearing
- ❑ Speech
- ❑ Difficulty Walking
- ❑ Weakness
- ❑ Breathing Problems
- ❑ Positive TB Test
- ❑ Vision
- ❑ Loose/Chipped Teeth
- ❑ Capped/False Teeth
- ❑ Circulation Problems
- ❑ Stomach Problems
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Bowel Problems
- ❑ Liver Problems
- ❑ Hepatitis
- ❑ Gallbladder
- ❑ Kidney
- ❑ Pain – Location:
- ❑ Frequent Falls
- ❑ Immune System Problems
- ❑ Chronic Cough
- ❑ Other: _____
- ❑ Abnormal Pap smears
- ❑ Reproductive organs
- ❑ Dialysis
- ❑ Thyroid
- ❑ Heart problems
- ❑ Blood clots
- ❑ Bleeding
- ❑ High Blood pressure
- ❑ Stroke
- ❑ Diabetes
- ❑ Seizures
- ❑ Epilepsy
- ❑ Cancer – Location:
- ❑ Bones
- ❑ Lung Problems
- ❑ TB

Explain any checked boxes:

List any previous hospitalizations/surgeries/invasive procedures:

List all allergies (include drug allergies):

List all medications:

Implant: ❑ **YES** ❑ **NO** **Manufacturer:** **Model:** **SN:**

Alcohol: ❑ **YES** ❑ **NO** **How often if yes:**

Tobacco: ❑ **YES** ❑ **NO**

Recreational drugs: ❑ **YES** ❑ **NO** **What if yes:**

Caffeine: ❑ **YES** ❑ **NO** **How often if yes:**

Patient, Parent or Guardian Signature **Date**
(*If completed by someone other than patient, relationship to patient)*

Staff Signature **Date**