BAROMEDICAL ASSOCIATES, LLC
Hyperbaric Oxygen Therapy

Patient Demographic Form

Please Check your Clinic Preference:

Willow Bend HBO	Texas Sports Hyperbarics	Global Generations HBO	BaroMed HBO
2633 Dallas Pkwy #200	6301 Snider Plaza #150	Kiddo2s Pediatric HBO	456 State Hwy 121
Plano, TX 75093	Dallas, TX 75205	3716 Standbridge Dr. #202	Bldg. 2, # 140
(972) 403-0403	(214) 389-6475	The Colony, TX 75056	Coppell, TX 75019
		(972) 559-9593	(972) 403-7784
☐	☐	☐	☐

Patient Name: _____ ☐ **Male** ☐ **Female**

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

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

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

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

Referred By: _____ **Preferred Language:** _____

Condition Being Treated: _____

Symptoms: _____

_____

Patient Medical History (Check any Past/Current Problems):

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

Explain Any Checked Boxes: _____

_____

BAROMEDICAL ASSOCIATES, LLC
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List any Previous Hospitalizations/Surgeries/Invasive Procedures: _____

_____

List All Allergies (including 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