



MEDICAL HISTORY

Support Person/ Caregiver Form

Have you had or are you taking any of the following: (yes or no)

- | | |
|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hay fever (frequent/severe) |
| <input type="checkbox"/> Previous HBOT | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Any form of lung condition |
| <input type="checkbox"/> Rheumatic condition | <input type="checkbox"/> Chest surgery |
| <input type="checkbox"/> Decompression sickness | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Recurring migraine headache | <input type="checkbox"/> Epilepsy/seizure condition |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Blackout/fainting (full/partial) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood vessel surgery |
| <input type="checkbox"/> Heart/angina condition | <input type="checkbox"/> Drug abuse/alcohol abuse |
| <input type="checkbox"/> Removable dentures | <input type="checkbox"/> Smoking/tobacco use |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ear surgery |
| <input type="checkbox"/> Asthma/wheezing w/breathing | <input type="checkbox"/> Bleeding/blood disorder |
| <input type="checkbox"/> Problems with equalizing ears | <input type="checkbox"/> Colostomy |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Sinus condition |

The information that I have provided concerning my medical history is accurate to the best of my knowledge.

(Support person/caregiver signature)

(Date)