



## MEDICAL HISTORY Client Form

Primary diagnosis \_\_\_\_\_ Secondary diagnosis \_\_\_\_\_

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/sinus condition      |
| <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/convulsion         |
| <input type="checkbox"/> Claustrophobia                 | <input type="checkbox"/> Blackout/fainting (full or 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 with 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                  |  |

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

\_\_\_\_\_  
(Client or guardian signature)

\_\_\_\_\_  
(Date)