HOC HEALTH CENTRE

COQUITLAM SITE

MEDICAL HISTORY QUESTIONNAIRE

Date: ______________________ Name: ____________________________

Date of Birth: ______________ Accompanying Parent/Guardian: ____________________

Address: ____

City: ___________________________Prov./State ________________ Postal/Zip _____________

Country: __________________________

Telephone: (________)_______________________ Fax: (______)______________________

E-mail address: _____________________________

Medical Diagnosis: (For which illnesses or symptoms are you seeking HBO treatment?)

____

When did this condition start? ____

What treatment have you had for this illness (including previous HBOT)? ____________________

____

What other illness do you have? ____

Are you presently or have received treatment for any other condition? Yes ______ No ________

If yes, please describe: ____

If over 40 years old, date, location and result of last chest x-ray: ___________________________

____

What operations have you had and, if any, when? __________________________________

____

Allergies: Yes ________ No __________

If yes, please list allergies: ____

____

Have you had any of the following conditions?

(f yes, please give date.)

	Yes	*No*	*Date*	*Describe*
Ear surgery				
Lung problems/surgery				
Emphysema				
Frequent colds				
Allergies				
Heart problems				
Heart attacks				
Angina				
Rheumatic condition				
High blood pressure				
Stroke				
Weakness in limbs				
Hearing aids				
Dentures				
Colostomy				
Blood sugar problems				
Claustrophobia				
Artificial limbs				
Blackouts				
Forgetfulness				
Fainting				
Seizures				
Asthma				
Intellectual deficit				
Cancer				
Diabetes				
Previous rhizotomy				

Have you taken recently or are you now taking any medication for the following conditions:

	Yes	*No*
Heart		
Blood pressure		
Infections (antibiotics, tablets, capsules, ointments)		
Sleeping pills		
Tranquilizers or Nerve pills		
Water pills (diuretics)		
Blood thinners		
Diabetic medicine		
Vitamins or Tonics		
Diet pills		
Pick-me-ups (stimulants)		

Please list other medications and the dosages you are presently taking:

____

____

Walking ability: Yes __________ No __________

Please describe: ____

Is there any other information you feel we should know?

____

____

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HO2C leaders in science-based natural medicine

What do you expect **HBO** would accomplish for you?

____

List the names and number of doctors from whom you are presently receiving treatment.

____

____

Where did you initially hear about **HBO** and our facility?

____

______________________________ ______________________________
Signature Date

Thank you for your cooperation.

Please fax or mail the completed form back to our Centre.

Office Use Only

The above patient has been screened and we recommend the following protocol:

Number of treatments recommended ____________________ at ___________________pressure.

Patient is currently on the following medications for his/her condition:

____

____

____

Advise of possible warnings: ____

Additional recommended protocol for preload or in conjunction with HBOT:

____

____

____

____

Signature Of HBOT Physician ______________________________ Date: ____________________

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