Southern Oregon Wellness Clinic
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Hyperbaric Oxygen Therapy New Patient Paperwork

Patient Name: _____

DOB: _____

Proposed number of treatments: _____ (# of treatments might increase or decrease based on clinical progression.)

I hereby authorize Southern Oregon Wellness Hyperbaric Treatment Center and its medical staff, to treat me with hyperbaric oxygen therapy as prescribed by the hyperbaric physician in a monoplace hyperbaric chamber. The nature and purpose of hyperbaric medicine has been explained to me and I hereby acknowledge that I understand the nature and purpose of these treatments. Additionally, I acknowledge the possible risks and side effects of hyperbaric oxygen therapy, including but not limited to those listed below. I have been given the opportunity to ask questions and have my questions answered by the hyperbaric physician.

Barotrauma or pain in the ears or sinuses. I may experience pain in the ears or sinuses. I also understand that if I am not able to equalize my ears or sinuses that pressurization will be slowed or halted; and suitable remedies will be applied.

Cerebral Air Embolism and Pneumothorax. Whenever there is a rapid change in the ambient pressure, there is a possibility of rupture of the lungs with escape of air into the arteries or into the chest cavities outside the lungs. This only occurs if the normal passage of air out of the lungs is blocked during recompression. Only slow recompressions are used in Hyperbaric Oxygen Therapy to obviate this possibility.

Oxygen toxicity. The risk of oxygen toxicity and seizures has been explained to me and will be minimized by never exposing me to greater pressure or longer times than are known to be safe for the body and its organs.

Risk of worsening of near-sightedness. (Myopia). It is possible I may experience a decrease in my ability to see things far away. I understand that this is usually temporary and that in most patients, vision returns to its pre-treatment level six weeks after the cessation of therapy. I understand that it is not advisable to get a new prescription for my glasses until at least eight weeks have passed after hyperbaric therapy.

Temporary improvement in far-sightedness. (Presbyopia). It is possible that I may experience an improvement in my ability to see things close or to read without reading glasses. I understand that this could be temporary and that in most patients, vision returns to its pre-

treatment level about six weeks after the cessation of therapy. I have been cautioned not to be fitted for new eyewear prescriptions for eight weeks after the end of my treatments.

Maturing or Ripening of Cataracts. In individuals with cataracts, it has occasionally been demonstrated that there may be a maturing or ripening of the cataracts.

Serous Otitis. Fluid in the ears sometimes accumulates because of breathing high concentrations of oxygen. This disappears after hyperbaric treatment ceases and often can be eased with decongestants.

I am aware that the practice of medicine and surgery is not an exact science and I have been made no promises or guarantees as to the results of Hyperbaric Oxygen Therapy. I have been informed by the staff of the Southern Oregon Wellness Hyperbaric Treatment Center that smoking cigarettes, pipes, cigars, or any other form of tobacco and the chewing of tobacco products will result in the ingestion of chemicals into the body which may affect the efficacy of success of hyperbaric treatment. I have been specifically told **NOT** to smoke during the entire duration of treatments.

I have read and agree to the information above. I have also, read and understand the Patient Safety Requirements and the products that are not allowed into the chamber at any time. I hereby understand that I am entering into hyperbaric treatment at my own risk. I hereby give my authorization and consent to the performance of Hyperbaric Oxygen Therapy by Southern Oregon Wellness Hyperbaric Treatment Center.

Patient or Authorized Representative/Date: _____

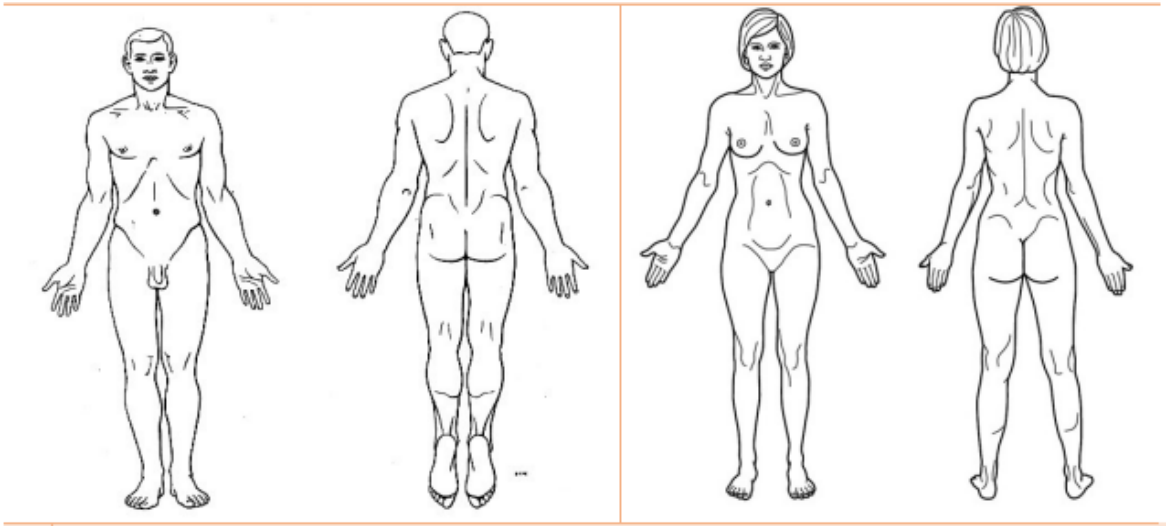
Hyperbaric Physician/ Date: _____

HBOT Intake Form

Name: _____ DOB**:** _____ Date: _____

PCP:_____

Please indicate where you suffer from pain or dysfunction:



Severity of pain: ____ Mild ____ Moderate ____ Severe

From 0 (no pain) to 10 (agonizing): At best ____/10 At worst ____0/10 Now ____/10

Quality:

❑ Aching ❑ Burning ❑ Sharp ❑ Cramping ❑ Spasming ❑ Numbing
❑ Electric shock

Frequency of pain: ___Intermittent ____Constant

Does your pain radiate? _____ yes or ____ no If so where?_____

_____

What makes your pain worse?

____ Bending ___Twisting ____Lifting ____ Weight bearing ___ Standing ____ Walking ____ Exercise

____ Reaching ____Looking up or down

Previous treatments:

___ Ice/heat ___ Physical Therapy ___ Steroid Injections ___ NSAIDS (Ibuprofen, Aleve, ect)

Other: _____

Do you have numbness, weakness, or tingling? If so, where?

_____

Musculoskeletal Medical History

Please indicate if you suffer from any of the following conditions:

Alcoholism	☐	**Migraines**	☐
Hepatitis	☐	**History of fainting**	☐
AIDS	☐	**Lyme disease**	☐
Anemia	☐	**Other chronic infection**	Type:
Low platelet count	☐	**Gout**	☐
Other bleeding disorder	Type:	**Rheumatoid arthritis**	☐
Sleep apnea	☐	**Psoriatic arthritis**	☐
Cancer	Type:	**Reactive arthritis**	☐
Diabetes	☐	**Other autoimmune condition**	Type:
COPD	☐	**Osteoporosis**	☐
Depression	☐	**Scoliosis**	☐
Anxiety	☐	**Ankylosing spondylitis**	☐
Drug abuse	☐	**DISH**	☐
Heart attack	☐	**Low thyroid**	☐
Heart disease	☐	**Low testosterone**	☐
Kidney disease	☐	**Low estrogen**	☐
Stroke	☐	**Other endocrine condition**	Type:
Generalized joint hypermobility	☐	**Ethlors-Danlos Syndrome**	☐

Medical History

Have you had or do you currently have any of the following? Please circle “Yes” or “No”.

Asthma	Yes or No	Cataracts	Yes or No	Claustrophobia	Yes or No
Congenital Spherocytosis	Yes or No	COPD/Lung Disease	Yes or No	Panic Attacks	Yes or No
Dental Disease	Yes or No	Dental Implants/ Dentures	Yes or No	Could You be Pregnant?	Yes or No
Epilepsy or Seizures	Yes or No	Fever (Currently)	Yes or No	Diabetes	Yes or No
Heart Failure	Yes or No	High Blood Pressure	Yes or No	Heart Disease	Yes or No
MRSA (Staphylococcus)	Yes or No	Optic Neuritis	Yes or No	HIV Positive or AIDS?	Yes or No
Pulmonary Cysts, Abscesses	Yes or No	Sinusitis	Yes or No	Pneumothorax	Yes or No
Upper Respiratory Infection	Yes or No	Viral Infection (Currently)	Yes or No	Collapsed Lung	Yes or No
Tachycardia/Bradycardia	Yes or No	Hypoglycemia	Yes or No	Thoracic Surgery	Yes or No

Note: If you have answered yes to any of the above questions, please explain. Example: (history of, being treated for, controlled/uncontrolled, occasional flare ups, etc.):

_____

_____

Please list <u>All</u> current medications and supplements:

Medication	**Dose**	**How many times daily**

Are you currently or have you recently taken any of the following? Please circle "Yes" or "No".

Acetazolamide	Yes or No	Alcohol	Yes or No	Amphetamines	Yes or No
Bleomycin	Yes or No	Chemotherapy Drugs	Yes or No	CIS-Platinum	Yes or No
Digitalis	Yes or No	Disulfram (Antabuse)	Yes or No	Doxorubicin (Adriamycin)	Yes or No
Epinephrine	Yes or No	Insulin	Yes or No	Intrathecal Pump	Yes or No
Lidocaine	Yes or No	Narcotics	Yes or No	Nicotine/Do You Smoke?	Yes or No
Nitroprusside	Yes or No	Phenothiazines	Yes or No	Steroids	Yes or No
Sulfamylon	Yes or No	Taxotere (Docetaxel/Taxol)	Yes or No	Anticonvulsants	Yes or No

Please list previous surgeries:

Surgery	**Date performed**

I affirm the above to be true to the best of my knowledge. I also understand that if any change in my medical condition or medications occurs at any time during my treatment that I must notify Southern Oregon Wellness staff immediately.

By signing below, I also understand this appointment does not establish me as a primary care patient with Southern Oregon Wellness Clinic.

_____ _____

Patient or Parent/ Guardian Signature Date