HBOT preliminary questionnaire for patients

NIIM
NATIONAL INSTITUTE OF INTEGRATIVE MEDICINE

Please ask your regular GP to review this form for your suitability for Hyperbaric Oxygen Therapy.

Have you ever had, or do you currently have:	Yes	No
Severe or frequent headaches/migraines		
Fainting or blackouts		
Convulsions, fits or epilepsy		
Head injury/concussion/loss of consciousness		
Anxiety/psychological problems/concerns		
Prescription glasses/contact lenses		
Eye/visual problems		
Dentures/dental plate/loose fillings		
Recent dental procedures/toothache		
Hay fever/sinusitis		
Nosebleeds		
Deafness/ringing in the ears		
Ear infections/ear discharge		
Have you smoked in the last 5 years/are you a current smoker		
Coughing up phlegm/blood		
Chronic/persistent cough/tuberculosis		
Pneumothorax/collapsed lung (or history of these)		
Frequent chest colds/flu		
Asthma/wheezing/use a puffer/inhaler		
Surgery to chest/lungs/heart		
Emphysema (COPD)/bronchiectasis		
Recurrent vomiting/diarrhea		
Heart disease/heart failure/heart attack/heart valve problem		
Palpitations/ability to feel your heart beating		
High blood pressure		
Rheumatic fever/pleurisy		
Pain/chest discomfort/shortness of breath on exertion		
Vomiting blood/passing red or black bowel motions		
Jaundice/hepatitis/liver disease		
Severe weight loss		
Hernia		
Back injury/significant joint problem/sports injury		
Limitation of movement		
Fracture/broken bone		
Kidney/bladder disease		
Diabetes/thyroid disease		
Bleeding problem/blood disease eg. Anaemia/sickle cell disease		
Skin disease		
Infectious illness		
Long Covid		

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Have you ever had, or do you currently have:	Yes	No
Cancer – if so where?		
Abnormal blood tests – if so when and what? (please bring with you if you have them)		
Heart pacemaker – brand name so we can check compatibility		
Continual blood glucose monitor		

Personal Details:

Name		**DOB**	
Address			
Phone Number			

Medications and Supplements:

Name of medication/supplement	Reason you are taking this	Dose and frequency

**** If more medications/supplements please list over page**

Are you self-referring for HBOT/has this been suggested by a current health practitioner?	
Are you currently being seen by one of the NIIM doctors?	**Doctors' name:**
Local GP (if different from above)?	
If you have previously had hyperbaric treatment, please list where, when and number of treatments.	

GP Name : _____

Provider Number: _____ Practice Name:_____

GP Signature _____ Date: _____

Please send the filled out form back to HBOT@niim.com.au