



**HYPERBARIC PHYSICIANS OF GEORGIA
INTAKE DATABASE**

FIRST NAME -- MIDDLE INITIAL -- LAST NAME		DATE OF BIRTH
PRIMARY PHYSICIAN		OTHER PHYSICIAN
OTHER PHYSICIAN		OTHER PHYSICIAN
PHARMACY		HOME HEALTH AGENCY
LIST YOUR MEDICATIONS BELOW:		LIST YOUR MEDICATIONS BELOW:
LIST YOUR DRUG ALLERGIES BELOW:		LIST YOUR DRUG ALLERGIES BELOW:
LIST YOUR MEDICAL DIAGNOSES / PAST MEDICAL HISTORY / HOSPITALIZATIONS BELOW:		
LIST THE SURGERIES / INVASIVE PROCEDURES YOU HAVE HAD BELOW:		

What is the location of your pain? _____

Rate your pain (on a scale of 1-10): Current _____ Worst _____ Best _____ Acceptable _____

<p>How would you describe your pain?</p> <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional <input type="checkbox"/> Continuous	<p>What is the quality of your pain?</p> <input type="checkbox"/> Ache <input type="checkbox"/> Cramping <input type="checkbox"/> Dull <input type="checkbox"/> Prick <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
<p>How long have you had this pain? _____</p>	<p>What causes an increase in your pain? _____</p>
<p>What relieves your pain?</p> <input type="checkbox"/> Medication <input type="checkbox"/> Relaxation <input type="checkbox"/> Exercise <input type="checkbox"/> Heat <input type="checkbox"/> Elevation <input type="checkbox"/> Cold <input type="checkbox"/> Nothing	<p>What parts of your life are affected by pain?</p> <input type="checkbox"/> Sleep <input type="checkbox"/> Appetite <input type="checkbox"/> Concentration <input type="checkbox"/> Quality of life <input type="checkbox"/> Emotions <input type="checkbox"/> Relationship
<p>What is your current pain management plan? _____</p>	
<p>What are your goals for pain management? _____</p>	
<p>FAMILY AND SOCIAL HISTORY</p>	
<p>What is your marital status?</p> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Widower <input type="checkbox"/> Significant other	<p>What is your current living situation?</p> <input type="checkbox"/> Alone <input type="checkbox"/> With family <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living <input type="checkbox"/> SNF (skilled nursing facility) <input type="checkbox"/> Homeless <input type="checkbox"/> Other
<p>Do you have a family member or friend that can assist in your care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>What is/was your primary career? _____</p>	
<p>Why did you retire? _____</p>	
<p>How would you describe your current activity level?</p> <input type="checkbox"/> Active <input type="checkbox"/> Minimal <input type="checkbox"/> Sedentary <input type="checkbox"/> Restricted	<p>How many packs of cigarettes do you smoke a day? _____</p> <p>What year did you start smoking? _____</p> <p>What year did you stop smoking? _____</p>
<p>How long does it take you to drink a six pack of beer, fifth of liquor, or bottle of wine?</p> <input type="checkbox"/> Unknown <input type="checkbox"/> Do not drink <input type="checkbox"/> A day <input type="checkbox"/> A week <input type="checkbox"/> A month <input type="checkbox"/> 6 months <input type="checkbox"/> A year	<p>What recreational drugs do you use? (check all that apply)</p> <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> LSD <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Heroin <input type="checkbox"/> Other
<p>What was the cause of death of your Mother? _____</p>	
<p>What was the cause of death of your Father? _____</p>	
<p>Are there any other pertinent diseases that run in your family? _____</p>	

REVIEW OF SYSTEMS

Please check () "yes" or "no" if you have had the following symptoms:

CONSTITUTIONAL

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Intended weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia (unable to sleep)	<input type="checkbox"/>	<input type="checkbox"/>	Unintended weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy (decreased level of alertness)	<input type="checkbox"/>	<input type="checkbox"/>	Intended weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Malaise (fatigue/tiredness)	<input type="checkbox"/>	<input type="checkbox"/>	Unintended weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>			

INTEGUMENTARY (SKIN AND/OR BREAST)

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer in old scar	<input type="checkbox"/>	<input type="checkbox"/>	Keloids (scar overgrowth)	<input type="checkbox"/>	<input type="checkbox"/>
Previous ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Contact dermatitis (rash from something touching your skin)	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Scars	<input type="checkbox"/>	<input type="checkbox"/>
Pruritus (itching)	<input type="checkbox"/>	<input type="checkbox"/>			

ALLERGIC/IMMUNOLOGIC

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>			

EYES

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Blind	<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>	Cataract removal	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>			

EARS, NOSE, MOUTH, THROAT

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Sinus surgery	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex (cold sores)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis (recurrent sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>
Recent respiratory infection	<input type="checkbox"/>	<input type="checkbox"/>	Partial dentures	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Spontaneous pneumothorax (lung collapse)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
			COPD (emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
Wear supplemental oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory infection	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR (HEART)					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Shortness of breath with exertion	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	PND (have to sit up to catch your breath when sleeping)	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia (abnormal heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (elevated blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>			
Hypotension (abnormally low blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>			
Orthopnea (difficulty breathing when lying flat on your back)	<input type="checkbox"/>	<input type="checkbox"/>			
CARDIOVASCULAR (PERIPHERAL CIRCULATION)					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
Arterial surgery	<input type="checkbox"/>	<input type="checkbox"/>	Claudication (leg pain with exercise)	<input type="checkbox"/>	<input type="checkbox"/>
Vein surgery	<input type="checkbox"/>	<input type="checkbox"/>	Rest pain	<input type="checkbox"/>	<input type="checkbox"/>
DVT (blood clot in leg/deep leg vein)	<input type="checkbox"/>	<input type="checkbox"/>	Necrosis/gangrene	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia (difficulty swallowing)	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Foley catheter	<input type="checkbox"/>	<input type="checkbox"/>	Nocturia (waking up to urinate)	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent catheter	<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal insufficiency	<input type="checkbox"/>	<input type="checkbox"/>
Suprapubic catheter	<input type="checkbox"/>	<input type="checkbox"/>	Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
Cystostomy	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>
Dysuria (pain with urination)	<input type="checkbox"/>	<input type="checkbox"/>	Peritoneal dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>			
MUSCULOSKELETAL					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Painful nails	<input type="checkbox"/>	<input type="checkbox"/>	Previous fracture	<input type="checkbox"/>	<input type="checkbox"/>
Myalgias (muscle pain)	<input type="checkbox"/>	<input type="checkbox"/>	Changes in feet	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Alteration of gait	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Focal headaches	<input type="checkbox"/>	<input type="checkbox"/>	Spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Syncope (passing out)	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	TIA (mini stroke)	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Hypoglycemia (low blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Addison's disease	<input type="checkbox"/>	<input type="checkbox"/>
Hyperglycemia (high blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Cushing's disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
HEMATOLOGIC/LYMPHATIC					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Hypercoaguable (clotting disorder)	<input type="checkbox"/>	<input type="checkbox"/>
Lymphedema	<input type="checkbox"/>	<input type="checkbox"/>	Family history of blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>			
PSYCHIATRIC					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Impaired judgment	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia (fear of closed spaces)	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Dementia/Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
HYPERBARIC					
	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Thoracic surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cancer history	<input type="checkbox"/>	<input type="checkbox"/>
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Congenital spherocytosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Recent high fevers	<input type="checkbox"/>	<input type="checkbox"/>
Cataract removal	<input type="checkbox"/>	<input type="checkbox"/>	Recent administration of:		
Spontaneous pneumothorax (lung collapse)	<input type="checkbox"/>	<input type="checkbox"/>	1. Cisplatinium	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	2. Adriamycin	<input type="checkbox"/>	<input type="checkbox"/>
Steroid use	<input type="checkbox"/>	<input type="checkbox"/>	3. Bleomycin	<input type="checkbox"/>	<input type="checkbox"/>
Previous hyperbaric treatment	<input type="checkbox"/>	<input type="checkbox"/>			