CUMMING
HYPERBARIC PHYSICIANS
OF GEORGIA
LYMPHEDEMA

Your Partners In Healing

INTAKE PATIENT DATABASE

Please Print Legibly

1505 Northside Boulevard, Suite 1300,
Cumming, GA 30041

P: 678-388-9511 ♦ F: 678-388-9544

.hbomdga.com

Date: _____

Patient Name Last: _____ First: _____ MI: __

Date of Birth: _____ Race: _____ Primary Language: _____ ☐ Male ☐ Female

Height: _____ Weight: _____

Referring Physician: _____ Phone/Fax: _____

Primary Physician: _____ Phone/Fax: _____

Other Physicians: _____ Phone/Fax: _____

REQUIRED

Pharmacy: _____ **Phone:** _____

Address/Street: _____

Home Health Agency: _____ Phone: _____

MEDICATIONS VITAMINS SUPPLEMENTS

MEDICATIONS/VITAMINS/SUPPLEMENTS	DOSAGE	MEDICATIONS/VITAMINS/SUPPLEMENTS	DOSAGE

ALLERGIES

ALLERGIES	Adverse Effect

YOUR MEDICAL DIAGNOSES

CURRENT OR PAST MEDICAL PROBLEMS

Approx. Date		Approx. Date	

PREVIOUS SURGERIES, OPERATIONS

☐ If you need more space, check the box and write on the back.

Where is the location of your pain?_____

Where is the location of your swelling?_____

Rate your pain (on a scale of 1-10):

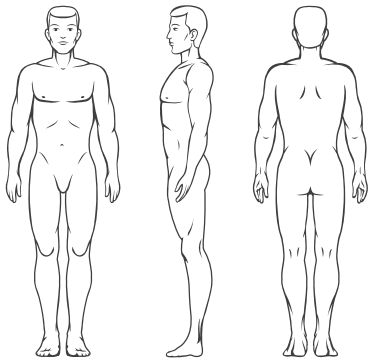
Current 1 2 3 4 5 6 7 8 9 10 Worse 1 2 3 4 5 6 7 8 9 10

Best 1 2 3 4 5 6 7 8 9 10 Acceptable 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? ☐ Intermittent ☐ Occasional ☐ Continuous

How long have you had this pain? _____

Circle the area that you are having swelling.



What is the quality of your pain? ☐ Ache ☐ Cramping ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing

What causes an increase in your pain, List all?_____ _____ _____

_____ _____ _____ _____

What causes an increase in your swelling, List all?_____ _____ _____

_____ _____ _____ _____

What relieves your swelling? ☐ Medication ☐ Heat ☐ Relaxation ☐ Elevation ☐ Exercise ☐ Cold ☐ Nothing

☐ Other _____

What parts of your life are affected by pain? ☐ Sleep ☐ Quality of life ☐ Appetite ☐ Emotions ☐ Concentration ☐ Relationship

What parts of your life are affected by Swelling?

☐ Sleep ☐ Quality of life ☐ Appetite ☐ Emotions ☐ Concentration ☐ Relationship

Do you sleep in a bed? ☐ Yes ☐ No If no where? _____

Is the swelling resolved when you wake up in morning? ☐ Yes ☐ No

Do you wear compression during the day? ☐ Yes ☐ No At night? ☐ Yes ☐ No

Have you been treated in the past for swelling? ☐ Yes ☐ No If yes, how long ago?_____What did the treatment program consist of?

_____

FAMILY AND SOCIAL HISTORY

What is your marital status? ☐ Married ☐ Single ☐ Widow ☐ Widower ☐ Separated ☐ Divorced ☐ Significant other

What is your current living situation? ☐ With family ☐ Alone ☐ SNF (Skilled Nursing Facility) ☐ Assisted living ☐ Other

Do you have a family member or friend that can assist in your care? ☐ Yes ☐ No If Yes, Who: _____

What is/was your primary career? _____ Are you Retired? ☐ Yes ☐ No

If yes why did you retire? _____

How would you describe your current activity level? ☐ Active ☐ Sedentary ☐ Minimal ☐ Restricted

Do you use? (Check all that apply) ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ None

Have you ever smoked? ☐ Yes ☐ No How many packs of cigarettes do you smoke a day? _____

What year did you start smoking? _____What year did you stop smoking? _____

How long does it take you to drink a six pack of beer, fifth of liquor, or bottle of wine?

☐ Do not drink ☐ Unknown ☐ A day ☐ A week ☐ A month ☐ 6 months ☐ A year

What recreational drugs do you use? (Check all that apply)

☐ None ☐ Marijuana ☐ Meth-amphetamines ☐ Cocaine ☐ Heroin ☐ LSD ☐ Other_____

Has your mother passed away? ☐ Yes ☐ No If yes what was the cause of death? _____

Has your father passed away? ☐ Yes ☐ No If yes what was the cause of death? _____

Are there any other pertinent diseases that run in your family? _____ _____

_____ _____ _____ _____

DOB:_____

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REVIEW OF SYSTEMS

CARDIOVASCULAR (HEART)								
Angina (Chest Pain)	Y☐	N☐	Hypotension (Low Blood Pressure)	Y☐	N☐	Palpitations	Y☐	N☐
Arrhythmia (Abnormal Heartbeat)	Y☐	N☐	MI (Heart Attack)	Y☐	N☐	PND (Have To Sit Up To Catch Your Breath When Sleeping)	Y☐	N☐
Chest Pain	Y☐	N☐	Murmur	Y☐	N☐			
CHF (Heart Failure)	Y☐	N☐	Orthopnea (Difficulty Breathing When Lying Flat On Your Back)	Y☐	N☐	Shortness of Breath with Exertion	Y☐	N☐
Defibrillator	Y☐	N☐						
Hypertension (Elevated Blood Pressure)	Y☐	N☐	Pacemaker	Y☐	N☐			
CARDIOVASCULAR (Peripheral)								
Arterial Surgery	Y☐	N☐	Leg Swelling	Y☐	N☐	Varicose Veins	Y☐	N☐
Claudication (Pain with Exercise/Walking)	Y☐	N☐	Necrosis/Gangrene	Y☐	N☐	Vein Surgery	Y☐	N☐
DVT (Blood Clot in Leg)	Y☐	N☐	Rest Pain	Y☐	N☐			
ENDOCRINE								
Addison's Disease	Y☐	N☐	Hyperglycemia (High Blood Sugar)	Y☐	N☐	Hypothyroidism	Y☐	N☐
Cushing's Disease	Y☐	N☐	Hyperthyroidism	Y☐	N☐	Thyroid Disease	Y☐	N☐
Diabetes	Y☐	N☐	Hypoglycemia (Low Blood Sugar)	Y☐	N☐			
LYMPHATIC/HEMATOLOGIC								
Bleeding Disorder	Y☐	N☐	Hypercoagulable (Clotting Disorder)	Y☐	N☐	Lipedema Phlebolymphedema		
Bruising	Y☐	N☐	Lymphedema	Y☐	N☐	Cancer	Y☐	N☐
GENITOURINARY								
Chronic Renal Insufficiency	Y☐	N☐	Foley Catheter	Y☐	N☐	Nocturia (Waking up to Urinate)	Y☐	N☐
Cystostomy	Y☐	N☐	Hemodialysis	Y☐	N☐	Swollen Genitals	Y☐	N☐
Dysuria (Pain with Urination)	Y☐	N☐	Intermittent Catheter	Y☐	N☐	Suprapubic Catheter	Y☐	N☐
ESRD (Renal Failure)	Y☐	N☐	Kidney Transplant	Y☐	N☐	Urinary Frequency	Y☐	N☐
MUSCULOSKELETAL								
Alteration of Gait	Y☐	N☐	Joint Stiffness	Y☐	N☐	Painful Nails	Y☐	N☐
Arthritis	Y☐	N☐	Joint Swelling	Y☐	N☐	Previous Fracture	Y☐	N☐
Changes in Feet	Y☐	N☐	Muscle Wasting	Y☐	N☐	Previous Amputation	Y☐	N☐
Charcot	Y☐	N☐	Myalgias (Muscle Pain)	Y☐	N☐			
RESPIRATORY								
Apnea	Y☐	N☐	COPD (Emphysema)	Y☐	N☐	Shortness of Breath	Y☐	N☐
Asthma	Y☐	N☐	Oxygen Dependence	Y☐	N☐	Spontaneous Pneumothorax (Lung Collapse)	Y☐	N☐
Blood Tinged Sputum	Y☐	N☐	Pulmonary Fibrosis	Y☐	N☐			
Bronchitis	Y☐	N☐	Respiratory Infection	Y☐	N☐	Tuberculosis	Y☐	N☐
Chronic Cough	Y☐	N☐	Seasonal Allergies	Y☐	N☐	Wear Supplemental Oxygen	Y☐	N☐
Cold Symptoms	Y☐	N☐	Snoring	Y☐	N☐	Wheezing	Y☐	N☐
NEUROLOGICAL								
Dizziness	Y☐	N☐	Paraplegia	Y☐	N☐	Stroke (CVA)	Y☐	N☐
Focal Headaches	Y☐	N☐	Parkinson's Disease	Y☐	N☐	Syncope (Passing Out)	Y☐	N☐
Migraine	Y☐	N☐	Quadriplegia	Y☐	N☐	TIA (Mini Strokes)	Y☐	N☐
Muscular Dystrophy	Y☐	N☐	Seizures	Y☐	N☐	Weakness	Y☐	N☐
Neuropathy	Y☐	N☐	Spinal Cord Injury	Y☐	N☐			
EARS, NOSE, MOUTH, THROAT								
Chronic Sinusitis (Recurrent Sinusitis)	Y☐	N☐	Eustachian Tube Problems	Y☐	N☐	Mid Ear Implants	Y☐	N☐
Dentures	Y☐	N☐	Hearing Loss	Y☐	N☐	Partial Dentures	Y☐	N☐
Difficulty Swallowing	Y☐	N☐	Herpes Simplex (Cold Sores)	Y☐	N☐	Sinus Surgery	Y☐	N☐
Ear Surgery	Y☐	N☐	Meniere's Disease	Y☐	N☐	Upper Respiratory Infection (Recent)	Y☐	N☐

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CONSTITUTIONAL								
Appetite Change	Y☐	N☐	Intended Weight Loss	Y☐	N☐	Pain	Y☐	N☐
Chills	Y☐	N☐	Lethargy (Decreased Level Of Alertness)	Y☐	N☐	Unintended Weight Gain	Y☐	N☐
Fever	Y☐	N☐	Malaise (Fatigue/Tiredness)	Y☐	N☐	Unintended Weight Loss	Y☐	N☐
Insomnia (Unable To Sleep)	Y☐	N☐	Night Sweats	Y☐	N☐	Weakness	Y☐	N☐
Intended Weight Gain	Y☐	N☐	Obesity	Y☐	N☐			
ALLERGIC/IMMUNOLOGIC								
AIDS	Y☐	N☐	Lupus	Y☐	N☐	Rheumatoid Arthritis	Y☐	N☐
Collagen Vascular Disease	Y☐	N☐	Pyoderma Gangrenosum	Y☐	N☐	Scleroderma	Y☐	N☐
HIV	Y☐	N☐	Latex Allergy					
EYES								
Blindness	Y☐	N☐	Contact Lenses	Y☐	N☐	Optic Neuritis	Y☐	N☐
Blurred Vision	Y☐	N☐	Glasses	Y☐	N☐	Retinal Detachment	Y☐	N☐
Cataract Removal	Y☐	N☐	Glaucoma	Y☐	N☐			
Cataracts	Y☐	N☐	Macular Degeneration	Y☐	N☐			
GASTROINTESTINAL								
Acid Reflux	Y☐	N☐	Cirrhosis of Liver	Y☐	N☐	Liver Disease	Y☐	N☐
Anorexia	Y☐	N☐	Constipation	Y☐	N☐	Malnutrition	Y☐	N☐
Ascites	Y☐	N☐	Diarrhea	Y☐	N☐	Vomiting	Y☐	N☐
Blood In Stools	Y☐	N☐	Dysphagia (Difficulty Swallowing)	Y☐	N☐	Nausea	Y☐	N☐
Bowel Incontinence	Y☐	N☐	Hepatitis	Y☐	N☐	Obesity	Y☐	N☐
Bulimia	Y☐	N☐	Hiatal Hernia	Y☐	N☐	Stomach Ulcers	Y☐	N☐
Change In Appetite	Y☐	N☐	Jaundice	Y☐	N☐	Colostomy (Colon Pouch)	Y☐	N☐
INTEGUMENTARY (SKIN AND/OR BREAST)								
Acne	Y☐	N☐	Hx Ulcer (open areas)	Y☐	N☐	Rashes	Y☐	N☐
Contact Dermatitis (Rash From Something Touching Your Skin)	Y☐	N☐	Keloids (Scar Overgrowth)	Y☐	N☐	Scars	Y☐	N☐
	Y☐	N☐	Pigment Change	Y☐	N☐	Drainage / Leakage	Y☐	N☐
Dryness	Y☐	N☐	Pruritus (Itching)	Y☐	N☐	Frequent Injections	Y☐	N☐
PSYCHIATRIC								
Anxiety	Y☐	N☐	Depression	Y☐	N☐	Psychosis	Y☐	N☐
Bipolar	Y☐	N☐	Impaired Judgment	Y☐	N☐	PTSD (Post Traumatic Stress Disorder)	Y☐	N☐
Claustrophobia (Fear of Closed Spaces)	Y☐	N☐	Memory Loss	Y☐	N☐			
Dementia/Alzheimer's	Y☐	N☐	Panic Attacks	Y☐	N☐			

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or authorized representative must attach documentation of such status.)

Date

_____ _____

Printed Name of Authorized Representative

Relationship/Capacity to Patient

DOB:_____

Last: _____ First: _____ MI:____