



Atlanta Hyperbaric & Wound Care Clinic, L.L.C.
Glenn L. Goodhart, M.D., J.D.
(404) 501-7316 or (404) 501-7312

PATIENT INFORMATION & HISTORY

Today's Date _____

☒ **GENERAL INFORMATION**

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Birth date _____ Age _____ Sex ___M ___F

SSN _____ Marital Status ___Single ___Married ___Widowed ___Divorced ___Separated

Emergency Contact _____ Relationship to Patient _____

Address _____ Daytime Phone _____

Who is your primary physician?

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip _____

Home Health Care _____ *Pharmacy* _____

Nursing Home _____ *Equipment at Home* _____

Have you ever been a patient at Atlanta Hyperbaric? _____

How did you learn of Atlanta Hyperbaric & Wound Care Clinic?

- Internet/Website
- Published Material or Newspaper
- Physician Name _____ Specialty _____ Phone _____
- Nurse
- Friend/Relative
- Other _____

☒ **EMPLOYMENT INFORMATION**

Employment Status ___Full-time ___Part-time ___Unemployed ___Retired, Retirement Date _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse/Nearest Relative _____

Spouse Date of Birth _____ Spouse Social Security Number _____

Spouse Address _____ Daytime Phone _____

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Spouse Employer _____ Spouse Retirement Date _____

Spouse Employer Address _____ City _____ State _____ Zip _____

Spouse Insurance Company _____ Policy Number _____

Does Workers Compensation cover this wound? Yes _____ No _____

☒ **WOUND HISTORY**

Wound location _____

How did your wound start? _____

Is your wound open and draining? _____

When did you first notice the wound? _____

Is your wound painful? Yes _____ No _____

Does your wound prevent you from performing daily activities? Yes _____ No _____

Has it ever healed and then reopened? Yes _____ No _____

How have you been treating your wound until now? _____

Have you had any lab work done in the past month? Yes _____ No _____ Who Ordered? _____

Have you had any tests for circulation on your legs? Yes _____ No _____ Where done? _____

Who ordered? _____

That you know of, have you ever had any other problems associated with your wound?

Infection Swelling (Please circle) Other _____

☒ **MEDICAL HISTORY**

	PATIENT		FAMILY		EXPLAIN (Who, Age)
Diabetes	Yes	No	Yes	No	
Hypertension	Yes	No	Yes	No	
Cancer	Yes	No	Yes	No	
Stroke	Yes	No	Yes	No	
Bleeding	Yes	No	Yes	No	
Acute Infections	Yes	No	Yes	No	
Hereditary Defects	Yes	No	Yes	No	
Heart Trouble	Yes	No	Yes	No	
Arthritis / Gout	Yes	No	Yes	No	
Convulsions / Seizures	Yes	No	Yes	No	

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☒ **SYSTEM REVIEW** (Please circle yes or no for each item)

GENERAL SYMPTOMS

Good general health lately	Yes	No
Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No
Height _____ Weight _____		

EYES

Blurred or double vision	Yes	No
Glaucoma	Yes	No
Wear glasses or contacts	Yes	No
Cataracts	Yes	No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic sinus problems or rhinitis	Yes	No
Nose bleeds	Yes	No
Mouth sores	Yes	No
Sore throat or voice change	Yes	No
Swollen glands in neck	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Swelling of feet, ankles or hands	Yes	No
Pacemaker	Yes	No

RESPIRATORY

Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No

GASTROINTESTINAL

Loss of appetite	Yes	No
Nausea or vomiting	Yes	No
Frequent diarrhea	Yes	No
Painful bowel movements	Yes	No
Constipation	Yes	No
Blood in Stool	Yes	No

MUSCULOSKELETAL

Joint Pain	Yes	No
Joint stiffness or swelling	Yes	No
Weakness of muscles or joints	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Difficulty in walking	Yes	No
Arthritis	Yes	No

INTEGUMENTARY (Skin)

Rash or itching	Yes	No
Varicose veins	Yes	No
Change in mole	Yes	No

NEUROLOGICAL

Frequent / recurring headaches	Yes	No
Light headed or dizzy	Yes	No
Convulsions or seizures	Yes	No
Poor sensation in feet	Yes	No
Paralysis	Yes	No
Stroke	Yes	No

PSYCHIATRIC

Memory loss or confusion	Yes	No
Depression	Yes	No
Claustrophobia	Yes	No

ENDOCRINE

Glandular or hormone problems	Yes	No
Thyroid disease	Yes	No
Diabetes	Yes	No
Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No

GENTOURINARY

Frequent urination	Yes	No
Burning/painful urination	Yes	No
Blood in urine	Yes	No
Incontinence/dribbling	Yes	No
Female – irregular periods	Yes	No
Female – pregnancies	Yes	No
Kidney failure	Yes	No
Dialysis	Yes	No

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☒ SOCIAL HISTORY

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Tobacco Use: Never _____ Previously, but quit _____ Current packs/day _____

Alcohol Use: Never _____ Rarely _____ Moderate _____ Daily _____

Drug Use: Never _____ Type/Frequency _____

Caffeine Use: Never _____ Type/Frequency _____

☒ CURRENT HEALTH STATUS (Please check one for each item)

Body Pain	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> Severe
Wound Pain	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> Severe
Energy	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> High
Physical Role Limitations	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> Severe
Emotional Role Limitations	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> Severe
Physical Functioning	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> High
Social Functioning	<input type="checkbox"/> None	<input type="checkbox"/> Some	<input type="checkbox"/> High
Mental Health	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Bad
Health Perception	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Bad

☒ ACTIVITIES OF DAILY LIVING (Please check one for each item)

Care for Appearance	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Use Toilet	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Bath/Shower	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Dress Self	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Feed Self	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Walk	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Get in/out bed	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Housework	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Prepare Meals	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Handle Money	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Take Medications	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Shop for Self	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able
Use telephone	<input type="checkbox"/> Completely Able	<input type="checkbox"/> Needs Assistance	<input type="checkbox"/> Not Able

☒ MEDICARE (Only fill out if currently receiving Medicare)

Have you ever received a kidney transplant? _____ Date Received _____

Do you participate in a Dialysis Program? _____ Date started _____

Do you participate in a Black Lung program? _____

Are services covered under a government program, such as a research grant? _____

Are you entitled to any Veteran's Administration (VA) benefits? _____

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☒ **IMMUNIZATION RECORD** (10 years old or younger only)

IMMUNIZATION	DATE RECEIVED

❖ **WHEN WAS THE DATE OF YOUR LAST TETANUS VACCINATION?** _____

☒ **NUTRITION PROFILE**

Difficulty chewing or swallowing? Yes No

Do you need assistance with eating? Yes No

Have you had a large weight loss or gain? (Please circle loss or gain) Yes No
 If yes, _____lbs in _____months
 Reason, if known _____

Special Diet? Yes No
 Please explain _____

Food allergies? Yes No
 Please explain _____

Are you involved in a weight loss program? Yes No

Appetite: Good Fair Poor (Please circle one)

How many meals do you eat each day? _____

Do you take vitamins or other supplements? Yes No
 Please explain _____

How much water do you drink each day? _____glasses

Do you exercise regularly? Yes No

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☒ INSURANCE INFORMATION

RESPONSIBLE PARTY

Person Responsible For Payment:

Same As Above _____

Name _____ Responsible Party SS# _____

Address _____ Phone# _____

Relationship to Patient _____

INSURANCE CARRIER

Primary Insurance _____ Policy# _____ Group# _____

Policy Holder's Name _____ SS# _____ Relationship _____

Secondary Insurance _____ Policy# _____ Group# _____

Policy Holder's Name _____ SS# _____ Relationship _____

* All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. I also authorize that payment be made directly to the provider.

Patient/Guardian Signature _____

Date _____