

## DIVING MEDICAL HISTORY FORM

(To Be Completed By Applicant-Diver)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_ Wt. \_\_\_\_\_ Ht. \_\_\_\_\_

Sponsor \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Dept./Project/Program/School, etc.) (Mo/Day/Yr)

**TO THE APPLICANT:**

Scuba diving makes considerable demands on you, both physically and mentally. Diving with certain medical conditions may be asking for trouble not only for yourself, but also to anyone coming to your aid if you get into difficulty in the water. Therefore, it is prudent to meet certain medical and physical requirements before beginning a diving or training program. Your answers to the questions are as important, in determining your fitness as your physical examination. Obviously, you should give accurate information or the medical screening procedure becomes useless.

This form shall be kept confidential. If you believe any question amounts to invasion of your privacy, you may elect to omit an answer, provided that you shall subsequently discuss that matter with your own physician and he/she must then indicate, in writing, that you have done so and that no health hazard exists. Should your answers indicate a condition, which might make diving hazardous, you will be asked to review the matter with your physician. In such instances, his/her written authorization will be required in order for further consideration to be given to your application. If your physician concludes that diving would involve undue risk for you, remember that he/she is concerned only with your well-being and safety. Please respect the advice and the intent of this medical history form.

	<b>Have you ever had or do you presently have any of the following?</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
1.	Trouble with your ears, including ruptured eardrum, difficulty clearing your ears, or surgery.			
2.	Trouble with dizziness.			
3.	Eye surgery.			
4.	Depression, anxiety, claustrophobia, etc.			
5.	Substance abuse, including alcohol.			
6.	Loss of consciousness.			
7.	Epilepsy or other seizures, convulsions or fits.			
8.	Stroke or a fixed neurological deficit.			
9.	Recurring neurologic disorders, including transient ischemic attacks.			
10.	Aneurysms or bleeding in the brain.			
11.	Decompression sickness or embolism.			
12.	Head injury			
13.	Disorders of the blood, or easy bleeding.			
14.	Heart disease, diabetes, high cholesterol			
15.	Anatomical heart abnormalities including patent foramen ovale, valve problems, etc.			
16.	Heart rhythm problems.			
17.	Need for a pacemaker			
18.	Difficulty with exercise.			
19.	High blood pressure			
20.	Collapsed lung			
21.	Asthma.			
22.	Other lung disease.			
23.	Diabetes mellitus.			
24.	Pregnancy			
25.	Surgery If yes explain below			
26.	Hospitalizations. If yes explain below			

	<b>Have you ever had or do you presently have any of the following?</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
27.	Do you take any medications? If yes list below			
28.	Do you have any allergies to medications, foods, environmental? If yes explain below			
29.	Do you smoke?			
30.	Do you drink alcoholic beverages?			
31.	Is there a family history of high cholesterol?			
32.	Is there a family history of heart disease or stroke?			
33.	Is there a family history of diabetes?			
34.	Is there a family history of asthma?			

Please explain any "yes" answers to the above questions.

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I certify that the above answers and information represent an accurate and complete description of my medical history.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date