Diving Medical History Form

APPENDIX 3

To Be Completed By Applicant-Diver

Name	Sex	Age	Weight	Height

Sponsor (Department / Project / Program / School / etc.)

Date (Month / Day / Year)

TO THE APPLICANT

SCUBA diving and snorkeling places considerable physical and mental demands on the diver. Certain medical and physical requirements must be met before beginning a diving or training program. Your accurate answers to the questions are more important, in many instances, in determining your fitness to dive than what the physician may see, hear or feel as part of the diving medical certification procedure.

This form shall be kept confidential by the examining physician. 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 who 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, their 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 they are concerned only with your well-being and safety.

YES	NO	Please indicate whether or not the following apply to you	Comments
○	○	Convulsions, seizures, or epilepsy	
○	○	Fainting spells or dizziness	
○	○	Been addicted to drugs	
○	○	Diabetes	
○	○	Motion sickness or sea/air sickness	
○	○	Claustrophobia	
○	○	Mental disorder or nervous breakdown	
○	○	Are you pregnant?	
○	○	Do you suffer from menstrual problems?	
○	○	Anxiety spells or hyperventilation	
○	○	Frequent sour stomachs, nervous stomachs or vomiting spells	
○	○	Had a major operation	
○	○	Presently being treated by a physician	
○	○	Taking any medication regularly (even non-prescription)	
○	○	Been rejected or restricted from sports	
○	○	Headaches (frequent and severe)	
○	○	Wear dental plates	
○	○	Wear glasses or contact lenses	
○	○	Bleeding disorders	
○	○	Alcoholism	
○	○	Any problems related to diving	
○	○	Nervous tension or emotional problems	
○	○	Take tranquilizers	
○	○	Perforated ear drums	

YES	NO	Please indicate whether or not the following apply to you	Comments
○	○	Hay fever	
○	○	Frequent sinus trouble, frequent drainage from the nose, post-nasal drip, or stuffy nose	
○	○	Frequent earaches	
○	○	Drainage from the ears	
○	○	Difficulty with your ears in airplanes or on mountains	
○	○	Ear surgery	
○	○	Ringing in your ears	
○	○	Frequent dizzy spells	
○	○	Hearing problems	
○	○	Trouble equalizing pressure in your ears	
○	○	Asthma	
○	○	Wheezing attacks	
○	○	Cough (chronic or recurrent)	
○	○	Frequently raise sputum	
○	○	Pleurisy	
○	○	Collapsed lung (pneumothorax)	
○	○	Lung cysts	
○	○	Pneumonia	
○	○	Tuberculosis	
○	○	Shortness of breath	
○	○	Lung problem or abnormality	
○	○	Spit blood	
○	○	Breathing difficulty after eating particular foods, after exposure to particu-lar pollens or animals	
○	○	Are you subject to bronchitis?	
○	○	Subcutaneous emphysema (air under the skin)	
○	○	Air embolism after diving	
○	○	Decompression sickness (DCS)	
○	○	Rheumatic fever	
○	○	Scarlet fever	
○	○	Heart murmur	
○	○	Large heart	
○	○	High blood pressure	
○	○	Angina (heart pains or pressure in the chest)	
○	○	Heart attack	
○	○	Low blood pressure	
○	○	Recurrent or persistent swelling of the legs	
○	○	Pounding, rapid heartbeat or palpitations	
○	○	Easily fatigued or short of breath	
○	○	Abnormal EKG	
○	○	Joint problems, dislocations or arthritis	

YES	NO	Please indicate whether or not the following apply to you	Comments
○	○	Back trouble or back injuries	
○	○	Ruptured or slipped disk	
○	○	Limiting physical handicaps	
○	○	Muscle cramps	
○	○	Varicose veins	
○	○	Amputations	
○	○	Head injury causing unconsciousness	
○	○	Paralysis	
○	○	Have you ever had an adverse reaction to medication?	
○	○	Do you smoke?	
○	○	Have you ever had any other medical problems not listed? If so, please list or describe below;	
○	○	Is there a family history of high cholesterol?	
○	○	Is there a family history of heart disease or stroke?	
○	○	Is there a family history of diabetes?	
○	○	Is there a family history of asthma?	
		Date of last tetanus shot?	
		Vaccination dates?	

EXPLAIN ANY YES ANSWERS ABOVE

CERTIFICATION

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

Diver Signature

Date