DIVE SAFETY

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 Co	omments
		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	



3

YES	NO	Please indicate whether or not the following apply to you Comments Hay fever Comments
		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



2 3

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



3 3