APPENDIX 3
DIVING MEDICAL HISTORY

Name: DOB: Height: Weight:

Sponsor: Date:
(Professor's Name)

TO THE APPLICANT:

Scuba diving 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. Please answer truthfully.

This form must 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 must 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.

No	Yes	No	Please indicate whether or not the following apply to you	Comments
1			Convulsions, seizures or epilepsy	
2			Fainting spells or dizziness	
3			Been addicted to drugs	
4			Diabetes	
5			Motion sickness or sea/air sickness	
6			Claustrophobia	
7			Mental disorder or nervous breakdown	
8			Are you pregnant	
9			Do you suffer from menstrual problems	
10			Anxiety spells or hyperventilation	
11			Frequent sour stomachs or vomitting spells	
12			Had a major operation	
13			Presently being treated by a physician	
14			Taking any medication regularly (prescription and non-prescription drugs)	
15			Been rejected or restricted from sporting activity	
16			Headaches (frequent or severe)	
17			Wear dental plates	
18			Wear glasses or contact lenses	
19			Bleeding disorders	
20			Alcoholism	
21			Any problems related to diving	

No	Yes	No	Please indicate whether or not the following apply to you	Comments
22			Nervous tension or emotional problems	
23			Take tranquilizers	
24			Perforated ear drums	
25			Hay fever	
26			Frequent sinus trouble, frequent drainage from the nose, post-nasal drip, or stuffy nose	
27			Frequent earaches	
28			Drainage from the ears	
29			Difficulty with your ears in airplanes or on mountains	
30			Ear surgery	
31			Ringing in your ears	
32			Hearing problems	
33			Trouble equalizing pressure in your ears (underwater or on planes or at altitude)	
34			Asthma	
35			Wheezing attacks	
36			Abnormal chest x-ray	
37			Cough (chronic or recurrent)	
38			Frequently raise sputum	
39			Pleurisy	
40			Collapsed lung (pneumothorax)	
41			Lung cysts	
42			Pneumonia	
43			Tuberculosis	
44			Shortness of breath	
45			Lung problem or abnormality	
46			Spit blood	
47			Breathing difficulty after eating particular foods, after particular exposure to particular pollens or animals	
48			Are you subject to bronchitis	
49			Subcutaneous emphysema (air under the skin)	
50			Air embolism after diving	

No	Yes	No	Please indicate whether or not the following apply to you	Comments
51			History of decompression sickness	
52			Rheumatic fever	
53			Scarlet fever	
54			Heart murmur	
55			Large heart	
56			High blood pressure	
57			Angina (heart pains or pressure in the chest)	
58			Heart attack	
59			Low blood pressure	
60			Recurrant or persistant swelling of the legs	
61			Pounding, rapid heartbeat or palpitations	
62			Easily fatigued or short of breath	
63			Abnormal EKG	
64			Joint problems, dislocations or arthritis	
65			Back trouble or injuries	
66			Ruptured or slipped disk	
67			Hernia	
68			Muscle cramps	
69			Varicose veins	
70			Amputations	
71			Head injuries causing unconsciousness	
72			Paralysis	
73			Have you ever had an adverse reaction to medication	
74			Do you smoke	
75			Limiting physical handicaps	
76			Family history of heart disease or stroke	
77			Family history of high cholesterol	
78			Family history of asthma	
80			Family history of diabetes	

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

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

Signature **Printed name** **Date**

- If applicable -

Physician's singature **Physician's printed name**

Clinic/Address **Date**