

# MEDICAL HISTORY

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in diving, SUB or snorkeling activities. A positive response to a question does not necessarily disqualify you from the activity. A positive response means that there is a pre-existing condition that may affect your safety while diving, using the SUB or snorkeling and you must seek the advice of your physician.

Please answer the following questions on your past or present medical history with a YES or NO. If you are not sure, answer YES. If any of these items apply to you, we may request that you consult with your physician prior to participating in scuba diving. **You must fill out each question in full (YES OR NO). An "N" or a "Y", blanks or lines are not acceptable and will hold up your check-in.**

Please list any allergies you may have:	
Do you regularly take prescription or non-prescription medications (except birth control or hormones)? Please list the names of the medications, dosage and what condition they are for.	

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| <p><input type="checkbox"/> Could you be pregnant?</p> <p><input type="checkbox"/> Do you have a <u>family history</u> of heart attacks or strokes?</p> <p><input type="checkbox"/> Have you ever had a heart attack?</p> <p><input type="checkbox"/> Have you ever had a stroke?</p> <p><input type="checkbox"/> Do you have allergy induced Asthma?</p> <p><input type="checkbox"/> Do you have exercise, anxiety or stress induced Asthma?</p> <p><input type="checkbox"/> Do you regularly use an asthma inhaler or take oral medication for asthma?</p> <p><b>Have you ever had or do you currently have...</b></p> <p><input type="checkbox"/> Frequent or severe attacks of hay fever or allergy?</p> <p><input type="checkbox"/> Frequent colds, sinusitis or bronchitis?</p> <p><input type="checkbox"/> Any form of lung disease?</p> <p><input type="checkbox"/> Pneumothorax (collapsed lung)?</p> <p><input type="checkbox"/> History of chest surgery?</p> <p><input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)?</p> <p><input type="checkbox"/> Behavioral health problems?</p> <p><input type="checkbox"/> Epilepsy, seizures or convulsions or take medication to prevent them?</p> <p><input type="checkbox"/> Recurring migraine headaches or take medication to prevent them?</p> | <p><input type="checkbox"/> Do you frequently suffer from motion sickness (seasick, carsick, etc?)</p> <p><input type="checkbox"/> History of diving accidents or decompression illness?</p> <p><input type="checkbox"/> History of recurrent back problems following surgery, injury or fracture?</p> <p><input type="checkbox"/> Inability to perform moderate exercise?</p> <p><input type="checkbox"/> History of diabetes?</p> <p><input type="checkbox"/> History of ear or sinus surgery?</p> <p><input type="checkbox"/> History of any heart disease?</p> <p><input type="checkbox"/> Angina or heart surgery or blood vessel pressure?</p> <p><input type="checkbox"/> History of high blood pressure, or take medications to control it?</p> <p><input type="checkbox"/> History of ear disease, hearing loss or problems with balance?</p> <p><input type="checkbox"/> History of problems equalizing ears with airplane or mountain travel?</p> <p><input type="checkbox"/> History of bleeding or other blood disorders?</p> <p><input type="checkbox"/> History of any type of hernia?</p> <p><input type="checkbox"/> History of ulcers or ulcer surgery?</p> <p><input type="checkbox"/> History of colostomy?</p> <p><input type="checkbox"/> History of drug or alcohol abuse?</p> <p><input type="checkbox"/> History of blackouts or fainting (full/partial loss of consciousness)?</p> |
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*The information I have provided about my medical history is accurate to the best of my knowledge.*

Signature \_\_\_\_\_

Date From: \_\_\_\_\_ Date To: \_\_\_\_\_

\_\_\_\_\_  
Please print your name clearly

\_\_\_\_\_  
Witness