

Full Name _____

Date of Birth _____

Social Security Number _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Please fill out this Medical History form and return it to CDA if you plan to obtain your physical on the first day of school.

Please contact Admissions for the Physical Forms if you plan to obtain the physical with your own UHMS-certified physician.

MEDICAL HISTORY

Do you now have, or have you ever suffered from, any of the following?			
	NO	YES	If "Yes", give details, including date(s) (month and year)
• Dental bridgework/plates			
• Facial pain			
• Allergies			
• Hayfever/allergic rhinitis			
• Sinus trouble			
• Nasal obstruction			
• Frequent or severe nosebleeds			
• Difficulty clearing ears when flying or diving			
• Ruptured eardrum			
• Ear infections			
• Hearing problems or hearing loss			
• Ringing in the ears			
• Dizziness			
• Persistent/chronic cough			
• Shortness of breath or trouble breathing			
• Wheezing, asthma			
• Wheezing on breathing cold air/exercising			
• Lung problems requiring inhalers/puffers			
• Bronchitis, pneumonia, or pleurisy			
• Tuberculosis			
• Pneumothorax/collapsed lung			
• Heart trouble or chest pain			
• Irregular/pounding heartbeat			
• High or low blood pressure			
• Blood vessel or circulation problems (including hands and feet)			
• Anemia, blood disorder, bleeding problems			
• Sea or other motion sickness			
• Frequent heartburn, indigestion			
• Peptic (gastric or duodenal) ulcer			
• Hiatus hernia			
• Frequent diarrhea			
• Blood/mucus in stool			
• Inflammatory bowel disease			
• Jaundice or hepatitis			

Figure B.1 (Continued)

MEDICAL HISTORY (Continued)

Do you now have, or have you ever suffered from, any of the following?			
	NO	YES	If "Yes", give details, including date(s) (month and year)
• Thyroid or glandular trouble			
• Diabetes			
• Kidney disease (including kidney stones)			
• Broken bones/dislocated joints			
• Rheumatism, arthritis, gout			
• Back injury or disease			
• Hernia (inguinal or umbilical)			
• Severe or frequent headaches			
• Migraines			
• Head injury or concussion			
• Fainting spells, blackouts			
• Convulsions, fits, seizures, or epilepsy			
• Muscle weakness, numbness/tingling			
• Neurological disease			
• Eye disease/injury/surgery or visual problems			
• Colour blindness			
• Skin trouble			
• Insomnia, nightmares, or sleepwalking			
• Nervous breakdown			
• Depression, mania, bipolar disorder			
• Marked anxiety or panic attacks			
• Claustrophobia			
• Fear of open spaces or heights			
• Alcohol or street drug problems			
• Heat or cold-related illness			
• Altitude illness			
• Other serious injury, illness or disease			
HAVE YOU EVER:			
• been hospitalized?			
• had any surgery?			
• been refused or left employment for medical reasons?			
ARE YOU:			
• Currently seeing a doctor for any problems?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, give details _____			
• Pregnant (or likely to be)?		<input type="checkbox"/> No <input type="checkbox"/> Yes	

Number

(Continued)

Figure B.1 (Continued)

PERSONAL HISTORY

List physically active recreational pursuits (other than diving):

Do you now (or did you in the past year):	NO	YES	If "Yes", give details, including what, when, how much, how often (daily, weekly, or monthly), and whether or not used before or between dives
• Smoke?	<input type="checkbox"/> never <input type="checkbox"/> quit (when) _____		
• Drink alcohol?			
• Take medicines prescribed by a doctor?			
• Take medicines bought without a prescription (over the counter)?			
• Use recreational/street drugs?			

DIVER'S DECLARATION

1) I declare that the contents of this form are accurate with regard to my history and present condition.

2) I authorize the release and exchange of relevant medical information between my family doctor, any examining doctors, and the provincial OHS authority for the purpose of determining my medical fitness to dive.

3) I authorize the release of this examination and classification of my medical fitness to dive to the provincial OHS authority.

Signature of Diver	Date
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COMMENTS (for doctor's use only)

Figure B.1 (Continued)