



2.4.3 ADCI MEDICAL HISTORY AND EXAMINATION FORMS



Association of Diving Contractors International
MEDICAL HISTORY FORM

Employer			Job Title		Date	
1. Last Name	First Name	Middle Name	2. Email Address		3. Date of Birth	4. Gender
					5. Last 4 No. of SSN	
6. Address (Number, Street)			7. City	8. State	9. Zip Code	10. Area Code - Phone Number ()
11. Emergency Contact Person - Relationship - Address - Telephone Number						12. Cell Phone Number ()

13. MEDICAL HISTORY: Have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Angiogram or ECHO	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	PFO Repair	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Injury
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arm/wrist/hand Injury
<input type="checkbox"/>	<input type="checkbox"/>	Disabling Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Hip/Leg/Ankle Injury
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury or "Trick Knee"
<input type="checkbox"/>	<input type="checkbox"/>	Severe Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble or Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints
<input type="checkbox"/>	<input type="checkbox"/>	Wear Contacts/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones or Fractures
<input type="checkbox"/>	<input type="checkbox"/>	Color Vision Defect	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease or Stones	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disease or Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Goiter or Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Perforated Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Clearing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding/Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	Anemia: Sickle Cell or Other
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash or Disease
<input type="checkbox"/>	<input type="checkbox"/>	Airway Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains	<input type="checkbox"/>	<input type="checkbox"/>	Staph Infections
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness/Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Protein, Sugar or Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Any Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Strain or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Prior Military Service
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Spine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness or Injury or Any Other Medical Condition
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc or Sciatica			
<input type="checkbox"/> <input type="checkbox"/> For Females ONLY			<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy			Last Menstrual Period _____

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES _____

14. LIST ALL SURGERIES _____ YEAR _____

15. LIST ALL HOSPITALIZATIONS _____ YEAR _____

16. LIST ALL INJURIES _____ YEAR _____

17. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER _____

18. ANSWER THE FOLLOWING QUESTIONS:

Every Item Checked Yes Must Be Fully Explained Below	YES	NO		YES	NO
Do you have any physical defects or any partial disabilities?			Have you ever resigned, been terminated, or changed jobs for medical reasons?		
Have you ever been rejected or rated for insurance, employment, license, or armed forces for health reasons?			Have you ever been dismissed from employment because of excess use of drugs or alcohol?		
Have you ever had illnesses, injuries, or lost time accidents from any work that you have done?			Do you have any allergies or reactions to food, chemicals, drugs, insect stings, or marine life?		
Have you been advised to have a surgical operation or medical treatment that has not been done?			Are you presently under the care of a physician? Give physician's name and address on the next page.		

COMMENTS: _____



19. My Personal Physician is: Name _____
 Address _____
 City, State _____
 Phone Number _____

20. DIVING HISTORY How long have you been commercial diving? _____

Surface Air Diving History		Saturation Diving History	
Maximum Depth Surface Air	_____	Heliox	Yes <input type="checkbox"/> No <input type="checkbox"/>
Maximum Depth Surface Mixed Gas	_____	Trimix	Yes <input type="checkbox"/> No <input type="checkbox"/>
Longest Bottom Time Air	_____	Nitrox	Yes <input type="checkbox"/> No <input type="checkbox"/>
Longest Bottom Time Mixed Gas	_____		
			Maximum Depth _____
			Maximum Duration (Days) _____

21. DIVING EXPERIENCE (Number of years experience):
 Name of Diving School _____
 Air _____
 Mixed Gases _____
 Saturation _____

22. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS
 If None put 0 (Zero) List any residuals
 Bends, pain only _____
 Bends, neurological _____
 Chokes _____
 Inner ear _____

23. IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)

Yes	No	Details	Yes	No	Details
<input type="checkbox"/>	<input type="checkbox"/>	Gas Embolism _____	<input type="checkbox"/>	<input type="checkbox"/>	Lung Squeeze _____
<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Near Drowning _____
<input type="checkbox"/>	<input type="checkbox"/>	CO ₂ Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Asphyxiation _____
<input type="checkbox"/>	<input type="checkbox"/>	CO Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (Dizziness) _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear/Sinus Squeeze _____	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Drum Rupture _____	<input type="checkbox"/>	<input type="checkbox"/>	Nitrogen Narcosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness _____	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness _____

24. Have you been involved in a diving accident (decompression sickness or others) since your last physical examination? Yes No

25. Date of last physical examination: _____ Name of Physician who performed your last exam _____
 For what company or organization were you last examined? _____ Address of Physician _____
 _____ City, State _____

26. Have you ever had any of the following? If so, give approximate date:

Yes	No	Give Date	Yes	No	Give Date
<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Function Studies _____
<input type="checkbox"/>	<input type="checkbox"/>	Longbone Series _____	<input type="checkbox"/>	<input type="checkbox"/>	Audiogram _____
<input type="checkbox"/>	<input type="checkbox"/>	Back (Spine) X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	EKG _____
<input type="checkbox"/>	<input type="checkbox"/>	MRI _____	<input type="checkbox"/>	<input type="checkbox"/>	Exercise (Stress) EKG _____

27. Physician Remarks: _____

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

Date _____ Signature _____



CDA Technical Institute

ADCI Offshore Diver Physical Exam and Additional Testing Fees Agreement

CDA Technical Institute requires all Air/Mixed Gas Commercial Diver program students to pass a diving physical examination administered by a physician certified through the Undersea Hyperbaric & Medical Society (UHMS) and approved by the Diver Certification Board of Canada (DCBC). CDA brings a Doctor and Medical Team on site the first day of school to perform the ADCI Offshore Diver Physical during New Student Orientation. Students are charged \$499 for the standard ADCI Off-Shore Diver Physical.

Should the Doctor/Medical team require additional testing beyond the ADCI Offshore Diver Physical (e.g. additional lab work, stress-test, etc.) to confirm student's "Fit to Dive" status, the student will be responsible for the additional testing fees.

Student Signature Date

School Official Signature Date