MEDICAL HISTORY INFORMATION FORM

NAME ____

ADDRESS ____

CITY ______________________ STATE/PROVINCE ________ZIP____________

HOME PHONE__________________________

MEDICAL HISTORY STATEMENT I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ears and sinuses are essential prerequisites for my safety and well-being. I hereby confirm that to the best of my knowledge my circulatory and respiratory systems and body air spaces are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness to the rigors of diving.

Write Y (yes) on N (no) next to all of the following, and explain any yes answers under Details.

____Behavioral health problems
____Claustrophobia
____Agoraphobia
____Migraine headaches
____Epilepsy
____Ear or hearing problems
____Trouble equalizing pressure
____Sinus trouble
____Severe hayfever
____Heart trouble
____High blood pressure
____Alcohol or drug abuse
____Asthma
____Rejected from any activity for medical reasons

____Bronchitis
____Tuberculosis
____Respiratory problems
____Back Problems
____Back/spinal surgery
____Diabetes
____Ulcers
____Regular medication
____Hernia
____Dizziness or fainting
____Recent surgery
____Angina
____Motion sickness
____Any medical condition not listed:
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____Contact lenses
____Dental plates
____Physical disability
____Serious injury
____Over 40 years old
____Hepatitis
____HIV positive
____Colostomy
____Drug allergies
____Pregnant
____Hospitalzed
____Heart surgery

Details, including any medications taken: ________________________________

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I certify that the above information is correct to the best of my knowledge.

Signature of participant:____Date:____________

I am a minor and my parent or guardian has signed below.

Signature of parent or guardian:_____________________________________Date:____________