Association of Diving Contractors International

MEDICAL HISTORY FORM

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

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

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

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES _____

13. LIST ALL SURGERIES YEAR

14. LIST ALL HOSPTALIZATIONS YEAR

15. LIST ALL INJURIES YEAR

16. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

17 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:

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

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

Surface Air Diving History

Maximum Depth Surface Air _____
Maximum Depth Surface Mixed Gas _____
Longest Bottom Time Air _____
Longest Bottom Time Mixed Gas _____

Saturation Diving History

Heliox Yes ☐ No ☐
Trimix Yes ☐ No ☐
Nitrox Yes ☐ No ☐

Maximum Depth _____
Maximum Duration (Days) _____

20. DIVING EXPERIENCE (Number of years experience):

Air ____
Mixed Gases ____
Saturation ____

Have you passed an oxygen tolerance test? Yes ☐ No ☐

Name of Diving School _____

21. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS
List any residuals

Bends, pain only ____ _____
Bends, neurological ____ _____
Chokes ____ _____
Inner ear ____ _____

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

	Yes	No	Details		Yes	No	Details
Gas Embolism	☐	☐		Lung Squeeze	☐	☐	
Oxygen Toxicity	☐	☐		Near Drowning	☐	☐	
CO_2 Toxicity	☐	☐		Asphyxiation	☐	☐	
CO Toxicity	☐	☐		Vertigo (Dizziness)	☐	☐	
Ear/Sinus Squeeze	☐	☐		Pneumothorax	☐	☐	
Ear Drum Rupture	☐	☐		Nitrogen Narcosis	☐	☐	
Deafness	☐	☐		Loss of Consciousness	☐	☐	

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

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 _____

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

Yes	No		Give Date	Yes	No		Give Date
☐	☐	Chest X-Ray		☐	☐	Nerve Condition Studies	
☐	☐	Longbone Series		☐	☐	Pulmonary Function Studies	
☐	☐	Back (Spine) X-Ray		☐	☐	Audiogram	
☐	☐	ENG		☐	☐	EKG	
☐	☐	EEG		☐	☐	Exercise (Stress) EKG	
☐	☐	EMG		☐	☐	MRI	

25. 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** _____