SCUBA DIVING MEDICAL HISTORY FORM

University of Florida
Division of Environmental Health and Safety
Diving Science and Safety Program

Applicant's Name _____ Date _____
Sex _____ Age _____ Weight _____ Height _____

To the Applicant:

SCUBA diving makes considerable demands on your physical and emotional condition. Diving with particular defects amounts to asking for trouble, not only to yourself, but to anyone coming to your aid if you get into difficulty in the water. Therefore, it is prudent to meet certain medical and physical requirements before beginning a diving or training program.

Your answers to these questions are more important, in many instances, in determining your fitness than what the physician may see, hear or feel when you are examined. Obviously, you should give accurate information or the medical screening procedure becomes useless.

This form shall be kept confidential. If you believe any question amounts to an invasion of your privacy, you may elect to omit an answer, provided that you subsequently discuss that matter with your own physician; he must then indicate, in writing, that you have done so and that no health hazards exist.

Should your answers indicate a condition which might make diving hazardous, you will be asked to review the matter with your physician. In such instances, his written authorization will be required in order for further consideration to be given to your application. If your physician concludes that diving would involve undue risk for you, remember that he is concerned only with your well-being and safety. Respect his advice and the intent of this medical history form.

I. General

1.	Have you ever had epilepsy (seizures)?	Yes ___ No ___	1
2.	Do you ever faint or have blackout spells?	Yes ___ No ___	2
3.	Have you ever been addicted to drugs?	Yes ___ No ___	3
4.	Do you have diabetes?	Yes ___ No ___	4
5.	Do you suffer from motion sickness or sea/air sickness?	Yes ___ No ___	5
6.	Are you prone to claustrophobia?	Yes ___ No ___	6
7.	Have you ever had a nervous breakdown?	Yes ___ No ___	7
8.	Are you pregnant?	Yes ___ No ___	8
9.	Do you suffer from menstrual problems?	Yes ___ No ___	9
10.	Do you get anxiety spells or hyperventilation?	Yes ___ No ___	10
11.	Do you get frequent sour stomachs, nervous stomachs or vomiting spells?	Yes ___ No ___	11
12.	Have you ever had a major operation?	Yes ___ No ___	12
13.	Are you presently being treated by a physician?	Yes ___ No ___	13
14.	Are you taking medication regularly?	Yes ___ No ___	14
15.	Have you ever been rejected or restricted from sports?	Yes ___ No ___	15
16.	Do you have frequent and severe headaches?	Yes ___ No ___	16
17.	Do you wear dental plates?	Yes ___ No ___	17
18.	Do you wear glasses/contact lenses?	Yes ___ No ___	18
19.	Do you have any bleeding disorders?	Yes ___ No ___	19
20.	Have you ever had any problem with alcoholism?	Yes ___ No ___	20
21.	Have you ever had any problems related to diving?	Yes ___ No ___	21
22.	Do you suffer from nervous tension or emotional problems?	Yes ___ No ___	22
23.	Do you sometimes take tranquilizers?	Yes ___ No ___	23.

II. Ears

24.	Have you ever had perforated ear drums?	Yes ___ No ___	24
25.	Do you have hay fever?	Yes ___ No ___	25
26.	Do you have frequent sinus trouble, frequent drainage from the nose, post-nasal drip or stuffy nose?	Yes ___ No ___	26

27.	Do you have drainage from the ears?	Yes ___ No ___	27
28.	Do you get frequent earaches?	Yes ___ No ___	28
29.	Do you have difficulty with your ears in airplanes or on mountains?	Yes ___ No ___	29
30.	Have you had ear surgery?	Yes ___ No ___	30
31.	Do you have ringing in your ears?	Yes ___ No ___	31
32.	Do you get frequent dizzy spells?	Yes ___ No ___	32
33.	Do you have any hearing problems?	Yes ___ No ___	33
34.	Do you have trouble equalizing pressure in your ears?	Yes ___ No ___	34

III. Lungs

35.	Have you ever had asthma?	Yes ___ No ___	35
36.	Have you ever had wheezing attacks?	Yes ___ No ___	36
37.	Do you have a chronic or recurrent cough?	Yes ___ No ___	37
38.	Do you frequently raise sputum?	Yes ___ No ___	38
39.	Have you ever had pleurisy?	Yes ___ No ___	39
40.	Have you ever had a collapsed lung (pneumothorax)?	Yes ___ No ___	40
41.	Do you have lung cysts?	Yes ___ No ___	41
42.	Have you had pneumonia?	Yes ___ No ___	42
43.	Have you ever had tuberculosis?	Yes ___ No ___	43
44.	Do you get shorter of breath than most people?	Yes ___ No ___	44
45.	Have you ever been told that you have a lung problem or abnormality?	Yes ___ No ___	45
46.	Do you ever spit blood?	Yes ___ No ___	46
47.	Do you ever have breathing difficulty after eating particular foods, or after exposure to particular pollens or animals?	Yes ___ No ___	47
48.	Are you subject to bronchitis?	Yes ___ No ___	48
49.	Have you ever had subcutaneous emphysema (air under the skin)?	Yes ___ No ___	49
50.	Have you ever had air embolism after diving?	Yes ___ No ___	50

IV. Heart

51.	Have you ever had rheumatic fever?	Yes ___ No ___	51
52.	Have you ever had scarlet fever?	Yes ___ No ___	52
53.	Have you ever been told you have a murmur?	Yes ___ No ___	53
54.	Have you ever been told you have a large heart?	Yes ___ No ___	54
55.	Have you ever had high blood pressure?	Yes ___ No ___	55
56.	Have you ever had angina (heart pains or pressure in chest)?	Yes ___ No ___	56
57.	Did you ever have a heart attack?	Yes ___ No ___	57
58.	Did you ever have low blood pressure?	Yes ___ No ___	58
59.	Do you have recurrent or persistent swelling of the legs?	Yes ___ No ___	59
60.	Have you ever had pounding, rapid heartbeat or palpitations?	Yes ___ No ___	60
61.	Have you ever had dizziness or fainting spells?	Yes ___ No ___	61
62.	Do you get fatigued or short of breath easily.	Yes ___ No ___	62
63.	Have you been told you had an abnormal EKG?	Yes ___ No ___	63

V. Bone Problems

64.	Do you suffer from joint problems / dislocations?	Yes ___ No ___	64
65.	Have you ever had back trouble or back injuries?	Yes ___ No ___	65
66.	Have you had a ruptured or slipped disc?	Yes ___ No ___	66
67.	Do you have any limiting physical handicaps?	Yes ___ No ___	67
68.	Do you suffer from muscle cramps?	Yes ___ No ___	68
69.	Do you have varicose veins?	Yes ___ No ___	69
70.	Do you have any amputations?	Yes ___ No ___	70
71.	Have you ever had a head injury causing unconsciousness?	Yes ___ No ___	71
72.	Have you experienced any paralysis?	Yes ___ No ___	72
73.	Have you ever had an adverse reaction to medication?	Yes ___ No ___	73
74.	Do you smoke?	Yes ___ No ___	74
75.	Have you ever had any other medical problems not listed? If so, please describe below.	Yes ___ No ___	75