



Divers Self Declaration Medical Questionnaire

Name.....Date of Birth.....Age.....
Postal Address.....City.....
Town.....State.....
Post/Zip Code.....Country.....

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a pre-existing condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in scuba diving.

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|---|--|
| <input type="checkbox"/> Could you be pregnant, or are you attempting to become pregnant? | <input type="checkbox"/> Dysentery or dehydration requiring medical intervention? |
| <input type="checkbox"/> Are you presently taking prescription medications? (with the exception of birth control or anti-malarial) | <input type="checkbox"/> Any dive accidents or decompression sickness? |
| <input type="checkbox"/> Are you over 45 years of age and can answer YES to one or more of the following? | <input type="checkbox"/> Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)? |
| <ul style="list-style-type: none">• currently smoke a pipe, cigars or cigarettes• have a high cholesterol level• have a family history of heart attack or stroke• are currently receiving medical care• high blood pressure• diabetes mellitus, even if controlled by diet alone | <input type="checkbox"/> Head injury with loss of consciousness in the past five years? |
| Have you ever had or do you currently have... | <input type="checkbox"/> Recurrent back problems? |
| <input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? | <input type="checkbox"/> Back or spinal surgery? |
| <input type="checkbox"/> Frequent or severe attacks of hayfever or allergy? | <input type="checkbox"/> Diabetes? |
| <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? | <input type="checkbox"/> Back, arm or leg problems following surgery, injury or fracture? |
| <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> High blood pressure or take medicine to control blood pressure? |
| <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> Heart disease? |
| <input type="checkbox"/> Other chest disease or chest surgery? | <input type="checkbox"/> Heart attack? |
| <input type="checkbox"/> Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)? | <input type="checkbox"/> Angina, heart surgery or blood vessel surgery? |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? | <input type="checkbox"/> Sinus surgery? |
| <input type="checkbox"/> Recurring complicated migraine headaches or take medications to prevent them? | <input type="checkbox"/> Ear disease or surgery, hearing loss or problems with balance? |
| <input type="checkbox"/> Blackouts or fainting (full/partial loss of consciousness)? | <input type="checkbox"/> Recurrent ear problems? |
| <input type="checkbox"/> Frequent or severe suffering from motion sickness (seasick, carsick, etc.)? | <input type="checkbox"/> Bleeding or other blood disorders? |
| | <input type="checkbox"/> Hernia? |
| | <input type="checkbox"/> Ulcers or ulcer surgery ? |
| | <input type="checkbox"/> A colostomy or ileostomy? |
| | <input type="checkbox"/> Recreational drug use or treatment for, or alcoholism in the past five years? |

Emergency Contact Information

Name of person to Contact.....Your Relationship with this person (Father, Friend, etc).....
His/Her Phone Number (.....).....His/Her email.....
His/Her mailing address.....

Name and address of your family physician

Physician.....Clinic/Hospital.....
Address.....
Date of last Physical Examination.....Name of Examiner.....

Were you ever required to have a Physical for Diving YES NO If so, when?.....

To the Participant:

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature.....**Date**.....