THE MEADOWS CENTER
FOR WATER AND THE ENVIRONMENT
TEXAS STATE UNIVERSITY

# APPENDIX 2: DIVING MEDICAL HISTORY FORM

**(To be completed by Applicant-Diver)**

Name:
Date: Sex: Age: Wt: Ht:

**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 for yourself but also for 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 the 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 will be kept confidential. If you believe any question(s) amounts to invasion of your privacy, you may elect to omit an answer, provided that you shall subsequently discuss the matter with your physician; and he/she must then indicate, in writing, that you have done so and that no health hazard exists.

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

| | **Have You Ever Had or Do You Presently Have Any of the Following? ANSWER WITH A YES OR NO TO THE FOLLOWING** | **Yes** | **No** | **Comments** |
|---|---|---|---|---|
| 1 | Trouble with your ears, including ruptured eardrum, difficulty clearing your ears, or surgery | | | |
| 2 | Trouble with dizziness | | | |
| 3 | Eye surgery | | | |
| 4 | Depression, anxiety, claustrophobia, etc | | | |
| 5 | Substance abuse, including alcohol | | | |
| 6 | Loss of consciousness | | | |
| 7 | Epilepsy or other seizures, convulsions or fits | | | |
| 8 | Stroke or a fixed neurological deficit | | | |
| 9 | Recurring neurologic disorders, including transient ischemic attacks | | | |
| 10 | Aneurysms or bleeding in the brain | | | |
| 11 | Decompression sickness or embolism | | | |
| 12 | Head injury | | | |
| 13 | Disorders of the blood, or easy bleeding | | | |
| 14 | Heart disease, diabetes, high cholesterol | | | |

| | Have You Ever Had or Do You Presently Have Any of the Following? ANSWER YES OR NO TO THE FOLLOWING | Yes | No | Comments |
|---|---|---|---|---|
| 15 | Heart rhythm problems | | | |
| 16 | Need for a pacemaker | | | |
| 17 | Difficulty with exercise | | | |
| 18 | High blood pressure | | | |
| 19 | Collapsed lung | | | |
| 20 | Asthma | | | |
| 21 | Other lung disease | | | |
| 22 | Diabetes mellitus | | | |
| 23 | Pregnancy | | | |
| 24 | Surgery If yes explain below | | | |
| 25 | Hospitalizations.<br>If yes explain below | | | |
| 26 | Do you take any medications?<br>If yes list below | | | |
| 27 | Do you have any allergies to medications, foods, environmentals?<br>If yes explain below | | | |
| 28 | Do you smoke? | | | |
| 29 | Do you drink alcoholic beverages? | | | |
| 30 | Is there a family history of high cholesterol? | | | |
| 31 | Is there a family history of heart disease or stroke? | | | |
| 32 | Is there a family history of diabetes? | | | |
| 33 | Is there a family history of asthma? | | | |

Please explain any "yes" answers to the above questions:

I certify that the above answers and information represent an accurate and complete description of my medical history.

_____

Signature Date