

Medical Statement and History

The purpose of this medical questionnaire is to find out if you should be examined by a physician before participating in recreational 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 a physician.

To Scuba dive safely, you must not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem, or who is under the influence of alcohol or drugs should not dive. If taking medication, consult a doctor and the instructor before participation in this program.

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, we must request that you consult with a physician prior to participating in Scuba diving. If you did not bring a current note from your physician specifically stating fitness for Scuba Diving, a list will be provided to you of local physicians.

- Are you pregnant?
- Do you regularly take prescription medications?
- Do you smoke a pack or more of cigarettes daily?
- Do you currently suffer from a cold or congestion?

Have you ever had or do you currently have:

- | | |
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| <input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? | <input type="checkbox"/> Unable to perform moderate exercise (example: run up a flight of stairs)? |
| <input type="checkbox"/> Frequent of severe attacks of hay fever or allergy? | <input type="checkbox"/> History of high blood pressure or take medicine to control blood pressure? |
| <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? | <input type="checkbox"/> History of any heart disease? |
| <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> History of heart attacks? |
| <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> Angina or heart surgery or blood vessel surgery? |
| <input type="checkbox"/> History of chest surgery? | <input type="checkbox"/> History of ear or sinus surgery? |
| <input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)? | <input type="checkbox"/> History of ear disease, hearing loss or problems with balance? |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or take medicine to prevent them? | <input type="checkbox"/> History of bleeding or other blood disorders? |
| <input type="checkbox"/> Recurring migraine headaches or take medicine to prevent them? | <input type="checkbox"/> History of ulcers or ulcer surgery? |
| <input type="checkbox"/> History of blackouts or fainting? | <input type="checkbox"/> History of colostomy)? |
| <input type="checkbox"/> History of diving accident's or decompression sickness | <input type="checkbox"/> History of drug or alcohol abuse? |
| <input type="checkbox"/> History of back surgery? | <input type="checkbox"/> Behavioural Health Problems? |
| <input type="checkbox"/> History of recurrent back problem? | |
| <input type="checkbox"/> History of diabetes? | |
| <input type="checkbox"/> History of back, arm or leg problems following surgery, injury or fracture? | |