

# Medical History and Physician Approval Form



NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE/PROVINCE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**MEDICAL HISTORY STATEMENT:** I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ear and sinus, are essential prerequisites for my safety and well-being. I hereby confirm that to the best of my knowledge my circulatory and respiratory systems and body air spaces are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness for the rigors of diving.

Write Y (yes) or N (no) next to all of the following, and explain under remarks, any yes answers.

Remarks:

	Behavioral health problems		Ulcers
	Claustrophobia		Colostomy
	Agoraphobia		Hernia
	Migraine Headaches		Dizziness or fainting
	Epilepsy		Recent surgery
	Ear or hearing problem		Hospitalized
	Trouble equalizing pressure		Pregnant
	Sinus trouble		Motion Sickness
	Severe hay fever		Glasses or contact lenses
	Heart trouble		Dental plates
	High blood pressure		Physical disability
	Angina		Serious injury
	Heart surgery		Over 40 years old
	Asthma		Hepatitis
	Bronchitis		HIV positive
	Tuberculosis		Regular medication
	Respiratory problems		Alcohol or drug abuse
	Back problems		Drug allergies
	Back/spinal surgery		Diabetes
	Rejected from any activity for medical reasons		Any medical condition not listed

**TO THE PHYSICIAN:** This person is an applicant for training in diving with self-contained underwater breathing apparatus (SCUBA). This is an activity that puts unusual stress on the individual in several ways. A list of contraindications is in this form for your reference.

Please note that the medical examination form presents a choice under IMPRESSION. We can only accept unconditional approval as stated for student applicants desiring to begin or continue training. If you conclude that diving is not in the individual's best interest or that their medical condition is likely to present a probable direct threat to others please discuss your opinion with the person and check disapproval. Please return this form to the student applicant.

**PHYSICIAN NOTES:**

IMPRESSION:

\_\_\_ APPROVAL (I find no medical conditions I consider incompatible with diving.)

\_\_\_ DISAPPROVAL (This applicant has medical conditions which in my opinion clearly would constitute unacceptable hazards to health and safety in diving.)

Date \_\_\_\_\_ Signature \_\_\_\_\_, MD.

Physician's Name (print) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_