HYPERBARIC AND REHABILITATIVE MEDICINE

Appendix 8.C

DIVING MEDICAL HISTORY FORM
(TO BE COMPLETED BY APPLICANT-DIVER)

Name _____Sex ____Age ____Weight _____ Height _____

Sponsor___Georgia Aquarium, Inc._____ Date _____
(Facility, etc.) (Monthly/Day/Year)

TO THE APPLICANT
Diving makes considerable demands on your physical and emotional condition. Diving with certain medical conditions may be 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 as important, in many instances, in determining your fitness as 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 you discuss the matter with the physician; and they must then indicate, in writing, that you have done so and that no health hazard exists.

If your answers indicate a condition(s) that might make diving hazardous, you will be asked to review the matter with your physician. In such instances, their 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 they are concerned only with your well-being and safety. Respect this advice and the intent of this medical history form.

	Yes	No	Please indicate whether or not the following apply to you	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 neurological disorders, including transient ischemic attacks	
10	☐	☐	Aneurysms or bleeding in the brain	

	Yes	No	Please indicate whether or not the following apply to you	Comments
11	☐	☐	Decompression sickness or embolism	
12	☐	☐	Head injury	
13	☐	☐	Disorders of the blood, or easy bleeding	
14	☐	☐	Heart disease, diabetes, high cholesterol	
15	☐	☐	Anatomical heart abnormalities including patent foramen oval, valve problem, etc.	
16	☐	☐	Heart rhythm problems	
17	☐	☐	Need for pacemaker	
18	☐	☐	Difficulty with exercise	
19	☐	☐	High blood pressure	
20	☐	☐	Collapsed lung	
21	☐	☐	Asthma	
22	☐	☐	Other lung disease	
23	☐	☐	Diabetes mellitus	
24	☐	☐	Pregnancy	
25	☐	☐	Surgery. If yes, explain below.	
26	☐	☐	Hospitalizations. If yes, explain below.	
27	☐	☐	Do you take medications? If yes, list below.	
28	☐	☐	Do you have allergies to medications, foods, and environments? If yes, please explain below.	
29	☐	☐	Do you smoke?	
30	☐	☐	Do you drink alcoholic beverages?	

Please explain "yes" to any of the above questions.

_____
_____
_____
_____
_____

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

_____ _____

Signature of Applicant Date (Month/Day/Year)