

DIVERS MEDICAL QUESTIONNAIRE

Participant Record - Confidential Information

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 diving 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**. If you answer **YES** to any of the questions below we will supply you with a PADI approved medical statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

___ Could you be pregnant or are you attempting to become pregnant?

___ Do you regularly take prescription or non-prescription medications? (with the exception of birth control or anti-malarial)

___ Are you over 45 years of age can answer YES to one or more of the following?

- currently smoke a pipe, cigars or cigarettes
- have a high cholesterol level
- have a family history of heart attacks or strokes
- are currently receiving medical care
- high blood pressure
- diabetes mellitus, even if controlled by diet alone

Have you ever had or do you currently have ...

___ Asthma, or wheezing with breathing, or wheezing with exercise?

___ Frequent or severe attacks of hayfever or allergy?

___ Frequent colds, sinusitis or bronchitis?

___ Any form of lung disease?

___ Pneumothorax (collapsed lung)?

___ Other chest disease or chest surgery?

___ Behavioural health, mental or psychological problems? (Panic attack, fear or closed or open spaces)?

___ Epilepsy, seizures, convulsions or take medications to prevent them?

___ Recurring migraine headaches or take medications to prevent them?

___ History of blackouts or fainting (full/partial loss of consciousness)?

___ Frequent or severe suffering from motion sickness (seasick, carsick etc.)?

___ Dysentery or dehydration requiring medical intervention?

___ Any dive accidents or decompression sickness?

___ Inability to perform moderate exercise (example walk 1.6 km/one mile within 12 minutes)?

___ Head injury with loss of consciousness in the past five years?

___ Recurrent back problems?

___ Back or spinal surgery?

___ Diabetes?

___ Back, arm or leg problems following surgery, injury or fracture?

___ High blood pressure or take medicine to control blood pressure?

___ Heart disease?

___ Heart attack?

___ Angina, heart surgery or blood vessel surgery?

___ Ear disease or surgery, hearing loss or problems with balance?

___ Recurrent ear problems?

___ Bleeding or other blood disorders?

___ Hernia?

___ Ulcers or ulcer surgery?

___ A colostomy or ileostomy?

___ Recreational drug use or treatment for, or alcoholism in the past five years?

The information that 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.

Name

Signature

Date