MEDICAL HISTORY FORM

Employer	Job Title	Date

1. Last Name / First Name / Middle Name	2. Date of Birth	3. Gender	4. SSN or PASSPORT No.

5. Address (Number, Street) / 6. City	7. State	8. Zip Code	9. Area Code – Phone Number
			( )

10. Emergency Contact Person – Relationship – Address – Telephone Number	11. Cell Phone Number
	( )

12. MEDICAL HISTORY: Have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
☐	☐	Convulsions or Seizures	☐	☐	Cardiac Angiogram or ECHO	☐	☐	Herniated Disc or Sciatica
☐	☐	Epilepsy	☐	☐	PFO Repair	☐	☐	Shoulder Injury
☐	☐	Concussion or Head Injury	☐	☐	High Blood Pressure	☐	☐	Elbow Injury
☐	☐	Disabling Headaches	☐	☐	Asthma or Wheezing	☐	☐	Arm/wrist/hand Injury
☐	☐	Loss of Balance/Dizziness	☐	☐	Coughing up Blood	☐	☐	Hip/Leg/Ankle Injury
☐	☐	Severe Motion Sickness	☐	☐	Tuberculosis	☐	☐	Knee Injury or "Trick Knee"
☐	☐	Unconsciousness	☐	☐	Shortness of Breath	☐	☐	Foot Trouble or Injuries
☐	☐	Fainting Spells	☐	☐	Chronic Cough	☐	☐	Dislocations
☐	☐	Wear Contacts/Glasses	☐	☐	Pneumothorax	☐	☐	Swollen Joints
☐	☐	Color Vision Defect	☐	☐	Lung Disease or Surgery	☐	☐	Broken Bones or Fractures
☐	☐	Eye Disease or Injury	☐	☐	Gallbladder Disease or Stones	☐	☐	Varicose Veins
☐	☐	Eye Surgery	☐	☐	Stomach Trouble or Ulcers	☐	☐	Muscle Disease or Weakness
☐	☐	Hearing Loss	☐	☐	Stomach Bleeding	☐	☐	Numbness or Paralysis
☐	☐	Ear Disease or Injury	☐	☐	Frequent Indigestion	☐	☐	Sleep Disorders
☐	☐	Ear Surgery	☐	☐	Jaundice	☐	☐	Diabetes
☐	☐	Perforated Eardrum	☐	☐	Liver Disease or Hepatitis	☐	☐	Goiter or Thyroid Disease
☐	☐	Difficulty Clearing	☐	☐	Rectal Bleeding/Blood in Stools	☐	☐	Blood Disease
☐	☐	Nose Bleed	☐	☐	Hemorrhoids (Piles)	☐	☐	Anemia: Sickle Cell or Other
☐	☐	Airway Obstruction	☐	☐	Gas Pains	☐	☐	Skin Rash or Disease
☐	☐	Hay Fever or Allergies	☐	☐	Crohn's Disease/Ulcerative Colitis	☐	☐	Staph Infections
☐	☐	Chest Pain	☐	☐	Rupture or Hernia	☐	☐	Tumor or Cancer
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Rheumatic Fever	☐	☐	Kidney Stones	☐	☐	Mental Illness/Depression/Anxiety
☐	☐	Heart Attack	☐	☐	Protein, Sugar or Blood in Urine	☐	☐	Nervous Breakdown
☐	☐	Abnormal Heart Rhythm	☐	☐	Joint Pain/Arthritis	☐	☐	Any Sexually Transmitted Disease
☐	☐	Heart Disease	☐	☐	Back Strain or Injury	☐	☐	Contagious Disease
☐	☐	Cardiac Stent or Angioplasty	☐	☐	Spine Problems	☐	☐	Other Illness or Injury or Any Other Medical Condition

		For Females ONLY				
☐	☐	Irregular Menses	☐	☐	Painful Menses	
			☐	☐	Pregnancy	Last Menstrual Period _____

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES _____

13. LIST ALL SURGERIES YEAR

14. LIST ALL HOSPTALIZATIONS YEAR

15. LIST ALL INJURIES YEAR

16. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

17 ANSWER THE FOLLOWING QUESTIONS:

Every Item Checked Yes Must Be Fully Explained Below	YES	NO		YES	NO
Do you have any physical defects or any partial disabilities?			Have you ever resigned, been terminated, or changed jobs for medical reasons?		
Have you ever been rejected or rated for insurance, employment, license, or armed forces for health reasons?			Have you ever been dismissed from employment because of excess use of drugs or alcohol?		
Have you ever had illnesses, injuries, or lost time accidents from any work that you have done?			Do you have any allergies or reactions to food, chemicals, drugs, insect stings, or marine life?		
Have you been advised to have a surgical operation or medical treatment that has not been done?			Are you presently under the care of a physician? Give physician's name and address on the next page.		

COMMENTS: _____

18. My Personal Physician is: Name _____

Address _____

City, State _____

Phone Number _____

19. DIVING HISTORY **How long have you been commercial diving?** _____

Surface Air Diving History

Maximum Depth Surface Air

Maximum Depth Surface Mixed Gas

Longest Bottom Time Air

Longest Bottom Time Mixed Gas

Saturation Diving History

Heliox Yes ☐ No

Trimix Yes ☐ No ☐

Nitrox Yes ☐ No

Maximum Depth _____

Maximum Duration (Days) _____

20. DIVING EXPERIENCE (Number of years experience):

Air ____

Mixed Gases ____

Saturation ____

Have you passed an oxygen tolerance test?

Yes ☐ No ☐

Name of Diving School _____

21. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS

If None put 0 (Zero) **List any residuals**

Bends, pain only ____ _____

Bends, neurological ____ _____

Chokes ____ _____

Inner ear ____ _____

22. IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)

	Yes	No	Details		Yes	No	Details
Gas Embolism	☐	☐		Lung Squeeze	☐	☐	
Oxygen Toxicity	☐	☐		Near Drowning	☐	☐	
CO_2 Toxicity	☐	☐		Asphyxiation	☐	☐	
CO Toxicity	☐	☐		Vertigo (Dizziness)	☐	☐	
Ear/Sinus Squeeze	☐	☐		Pneumothorax	☐	☐	
Ear Drum Rupture	☐	☐		Nitrogen Narcosis	☐	☐	
Deafness	☐	☐		Loss of Consciousness	☐	☐	

23. Have you been involved in a diving accident (decompression sickness or others) since your last physical examination? ☐Yes ☐No

Date of last physical examination: _____

For what company or organization were you last examined? _____

Name of Physician who performed your last exam _____

Address of Physician _____

City, State _____

24. Have you ever had any of the following? If so, give approximate date:

Yes	No		Give Date	Yes	No		Give Date
☐	☐	Chest X-Ray		☐	☐	Nerve Condition Studies	
☐	☐	Longbone Series		☐	☐	Pulmonary Function Studies	
☐	☐	Back (Spine) X-Ray		☐	☐	Audiogram	
☐	☐	ENG		☐	☐	EKG	
☐	☐	EEG		☐	☐	Exercise (Stress) EKG	
☐	☐	EMG		☐	☐	MRI	

25. Physician Remarks: _____

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

Date _____ **Signature** _____

PHYSICAL EXAMINATION FORM

Employer	Date	Date of Birth	Age

1. Last Name	First Name	Middle Name	2. SSN or PASSPORT No.

3. Height (inches)	4. Weight (pounds)	5. Body Fat (%) (Optional)	6. BMI (Optional)

7. Temperature	8. Blood Pressure	9. Pulse/Rhythm	10. General Appearance/Hygiene	11. Build
	/			

12. Distant Vision:	13. Near Vision: Jaeger	Near Vision Corrected	14. Color Vision (Test Performed and Results)
R. 20/_____ Corr. to 20/_____	R. 20/_____	R. 20/_____	
L. 20/_____ Corr. to 20/_____	L. 20/_____	L. 20/_____	

15. Field of Vision (Degrees) R ° L °

16. Contact Lenses ☐ Yes ☐ No

NORMAL	ABNORMAL	Check each item in appropriate column (enter NE for Not Evaluated)	REMARKS
		17. Head, Face, Scalp	
		18. Neck	
		19. Eyes	
		20. Ears – General (internal and external canal)	
		21. Eustachian Tube Function	
		22. Tympanic Membrane	
		23. Nose (Septal Alignment)	
		24. Sinuses	
		25. Mouth and Throat	
		26. Chest	
		27. Lungs	
		28. Heart (Thrust, Size, Rhythm, Sounds)	
		29. Pulses (Equality, etc.)	
		30. Vascular System (Varicosities, etc.)	
		31. Abdomen and Viscera	
		32. H ernia (All Types)	
		33. Endocrine System	
		34. G-U System	
		35. Upper Extremities (Strength, ROM)	
		36. Lower Extremities (Except Feet)	
		37. Feet	
		38. Spine	
		39. Skin, Lymphatics	
		40. Anus and Rectum	
		41. Sphincter Tone	
		42. Pelvic Exam	

NEUROLOGICAL EXAMINATION

43. CRANIAL NERVES

		NORMAL	ABNORMAL	NE
I	Olfactory			
II	Optic			
III	Oculomotor			
IV	Trochlear			
V	Trigeminal			
VI	Abducens			

		NORMAL	ABNORMAL	NE
VII	Facial			
VIII	Auditory			
IX	Glossophayrngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

44. REFLEXES

DEEP TENDON

	Left					Right				
	0	1	2	3	4	0	1	2	3	4
Triceps										
Biceps										
Patella										
Achilles										

PATHOLOGICAL

	Left		Right	
	Present	Absent	Present	Absent
Babinski				
Hoffman				
Ankle Clonus				

SUPERFICIAL

	Present	Absent	NE
Upper Abdomen			
Lower Abdomen			
Cremasteric			

45. CEREBELLAR FUNCTION

	0	1	2	3	4
Ataxia					
Tremor (intention)					

	Normal	Abnormal
Finger to Nose		
Heel to Shin (Sliding)		

46. MUSCLE STRENGTH

	1	2	3	4	5
Right Upper Extremity					
Left Upper Extremity					
Right Lower Extremity					
Left Lower Extremity					

TONE

Normal	Abnormal

47. PROPIOCEPTION

	Left		Right	
	Normal	Abnormal	Normal	Abnormal
Joint Position Sense				
Stereognosis				
Vibratory Sensation				

48. NYSTAGMUS

	Present	Absent
End Point Lateral Gaze		
Pathological		

49. SENSATION

	Normal	Abnormal
Hot		
Cold		

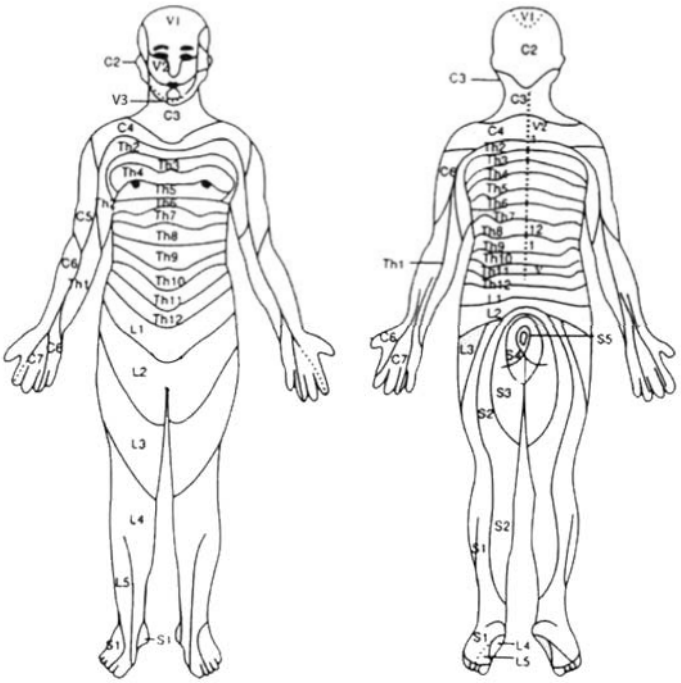
	Normal	Abnormal
Sharp		
Soft		

Two Point Discrimination	
Normal	
Abnormal	

50. RHOMBERG

Absent	
Present	

51. MISCELLANEOUS REMARKS



LABORATORY FINDINGS

52. Urinalysis

Color _____
Appearance _____
Sp. Gravity _____
Ph _____

	0	1+	2+	3+	4+
Sugar					
Blood					
Ketones					
Bilirubin					
Protein					

53. Blood Tests

CBC
Normal ☐
Abnormal ☐

Sickle Cell ☐ Pos ☐ Neg

Attach Reports
RPR ☐ Pos ☐ Neg
HIV ☐ Pos ☐ Neg

54. Pulmonary Function

FVC _____
FEV1 _____
FEV1/FVC _____

55. X-rays

	Normal	Abnormal	(Describe)
Chest	☐	☐	
Lumbar Spine	☐	☐	
Long Bone Series	☐	☐	
Other	☐	☐	

56. Electrocardiogram

Static _____
Exercise Stress _____

57. Audiogram

Hz	500	1000	2000	3000	4000	6000	8000
Left							
Right							

58. Comprehensive Metabolic Panel Attach Report

Normal ☐
Abnormal ☐

Lipid Panel (if done)

Normal ☐
Abnormal ☐

Comments: _____

59. Drug Screen

☐ Not collected
☐ Collected, results sent to employer

Work Status:

☐ Fit for diving
☐ Cleared for supervisor
☐ Cleared for topside work only
☐ Cleared with restrictions: _____
☐ Further evaluation needed: _____
☐ Unfit for diving : _____
☐ Unfit _____

Comments: _____

Examinee Signature _____
Examinee Name _____
Physician Signature _____
Physician Name _____
Address _____
Phone Number _____

Date of Examination _____