# 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**( ) |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Yes | No | Convulsions or Seizures | Yes | No | Cardiac Angiogram or ECHO | Yes NoHerniated Disc or Sciatica |
|  |  | EpilepsyConcussion or Head Injury Disabling HeadachesLoss of Balance/Dizziness Severe Motion Sickness UnconsciousnessFainting SpellsWear Contacts/Glasses Color Vision Defect Eye Disease or Injury Eye SurgeryHearing LossEar Disease or Injury Ear Surgery Perforated Eardrum Difficulty Clearing Nose BleedAirway Obstruction Hay Fever or Allergies Chest PainHeart Murmur Rheumatic Fever Heart AttackAbnormal Heart Rhythm Heart DiseaseCardiac Stent or Angioplasty |  |  | PFO RepairHigh Blood Pressure Asthma or Wheezing Coughing up Blood Tuberculosis Shortness of Breath Chronic Cough PneumothoraxLung Disease or Surgery Gallbladder Disease or Stones Stomach Trouble or Ulcers Stomach BleedingFrequent Indigestion JaundiceLiver Disease or Hepatitis Rectal Bleeding/Blood in Stools Hemorrhoids (Piles)Gas PainsCrohn’s Disease/Ulcerative Colitis Rupture or HerniaKidney Disease Kidney StonesProtein, Sugar or Blood in Urine Joint Pain/ArthritisBack Strain or Injury Spine Problems | Shoulder Injury Elbow Injury Arm/wrist/hand Injury Hip/Leg/Ankle InjuryKnee Injury or “Trick Knee” Foot Trouble or Injuries DislocationsSwollen JointsBroken Bones or Fractures Varicose VeinsMuscle Disease or Weakness Numbness or ParalysisSleep Disorders DiabetesGoiter or Thyroid Disease Blood DiseaseAnemia: Sickle Cell or Other Skin Rash or DiseaseStaph Infections Tumor or Cancer ClaustrophobiaMental Illness/Depression/Anxiety Nervous BreakdownAny Sexually Transmitted Disease Contagious DiseaseOther Illness or Injury or Any Other Medical Condition |
|  |  | For Females ONLYIrregular Menses |  |  | Painful MensesPregnancy | Last Menstrual Period  |

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES

1. **LIST ALL SURGERIES** YEAR
2. **LIST ALL HOSPTALIZATIONS** YEAR
3. **LIST ALL INJURIES** YEAR
4. **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 medicalReasons? |  |  |
| Have you ever been rejected or rated for insurance, employment, license, orArmed forces for health reasons? |  |  | Have you ever been dismissed from employment because of excess use ofDrugs or alcohol? |  |  |
| Have you ever had illnesses, injuries, or lost time accidents from any workThat you have done? |  |  | Do you have any allergies or reactions to food, chemicals, drugs, insectStings, or marine life? |  |  |
| Have you been advised to have a surgical operation or medical treatment thatHas not been done? |  |  | Are you presently under the care of a physician? Give physician’s nameAnd address on the next page. |  |  |

COMMENTS:

1. **My Personal Physician is:** Name

Address City, State

Phone Number

1. **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**

Maximum Depth

Heliox Yes No

Trimix Yes No Maximum Duration (Days) Nitrox Yes No

1. **DIVING EXPERIENCE (Number of years’ experience):**

Have you passed an oxygen tolerance test?

1. **INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS If None put 0 (Zero) List any residuals**

Air

Mixed Gases

Yes No

Bends, pain only bends, neurological

Saturation Name of Diving School

Chokes Inner ear

1. **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

CO2 Toxicity Asphyxiation

CO Toxicity Vertigo (Dizziness)

Ear/Sinus Squeeze Pneumothorax

Ear Drum Rupture Nitrogen Narcosis

Deafness Loss of Consciousness

1. **Have you been involved in a diving accident (decompression sickness or others) since your last physical examination?**

Date of last physical examination: Name of Physician who performed your last exam for what company or organization were you last examined? Address of Physician

City, State

Yes No

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

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

1. **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

1. **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 |  |  |  |

1. **REFLEXES**

**DEEP TENDON PATHOLOGICAL SUPERFICIAL**

Left Right

Left

Right

Triceps Biceps Patella Achilles

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **CEREBELLAR FUNCTION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 |
|  |  |  |  |  |
|  |  |  |  |  |
| Normal | Abnormal |
|  |  |
|  |  |

Ataxia

Tremor (intention)

Finger to Nose

Heel to Shin (Sliding)

1. **PROPIOCEPTION**

Babinski Hoffman Ankle Clonus

* 1. **MUSCLE**

|  |  |  |  |
| --- | --- | --- | --- |
| Present | Absent | Present | Absent |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Right Upper Extremity Left Upper Extremity Right Lower Extremity Left Lower Extremity

STRENGTH

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

* + 1. **NYSTAGMUS**

Upper Abdomen Lower Abdomen Cremasteric

TONE

|  |  |  |
| --- | --- | --- |
| Present | Absent | NE |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Normal | Abnormal |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

##

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

|  |  |  |
| --- | --- | --- |
|  | Present | Absent |
| End Point Lateral Gaze |  |  |
| Pathological |  |  |

* + 1. **SENSATION 50. RHOMBERG**

##

|  |  |  |
| --- | --- | --- |
|  | Normal | Abnormal |
| Hot |  |  |
| Cold |  |  |

|  |  |  |
| --- | --- | --- |
|  | Normal | Abnormal |
| Sharp |  |  |
| Soft |  |  |

|  |
| --- |
| Two Point Discrimination |
| Normal |  |
| Abnormal |  |

|  |  |
| --- | --- |
| Absent |  |
| Present |  |

51. MISCELLANEOUS REMARKS

LABORATORY FINDINGS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 0 | 1+ | 2+ | 3+ | 4+ |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **52. Urinalysis**Color Sugar Appearance Blood Sp. Gravity Ketones Ph BilirubinProtein | **53. Blood Tests** Attach ReportsCBC RPR PosNormal NegAbnormalHIV PosSickle Cell Pos NegNeg |
| **54. Pulmonary Function** | **55. X-rays** Normal Abnormal (Describe) |
| FVC  | Chest |
| FEV1  | Lumbar Spine  |
| FEV1/FVC  | Long Bone Series  |
|  | Other  |
| **56. Electrocardiogram**Static Exercise Stress  | **57. Audiogram** |
| **58. Comprehensive** Attach **Lipid Panel** Comments:**Metabolic Panel** Report (if done)Normal NormalAbnormal Abnormal  | **59. Drug Screen**Not collectedCollected, results sent to employer |

Work Status:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Hz | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
| Left |  |  |  |  |  |  |  |
| Right |  |  |  |  |  |  |  |

Fit for diving

Cleared for supervisor Examinee Signature Cleared for topside work only

Cleared with restrictions: Examinee Name

Further evaluation needed:

Unfit for diving: Physician Signature

Unfit

**Comments:** Physician Name

Address

Phone Number

Date of Examination