

# Association of Diving Contractors International

## 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	
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Angiogram or ECHO	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc or Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	PFO Repair	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Injury
<input type="checkbox"/>	<input type="checkbox"/>	Disabling Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Arm/wrist/hand Injury
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Hip/Leg/Ankle Injury
<input type="checkbox"/>	<input type="checkbox"/>	Severe Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury or "Trick Knee"
<input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble or Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations
<input type="checkbox"/>	<input type="checkbox"/>	Wear Contacts/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints
<input type="checkbox"/>	<input type="checkbox"/>	Color Vision Defect	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones or Fractures
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease or Stones	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disease or Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Perforated Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Goiter or Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Clearing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding/Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia: Sickle Cell or Other
<input type="checkbox"/>	<input type="checkbox"/>	Airway Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash or Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Staph Infections
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness/Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Protein, Sugar or Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Any Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Strain or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Spine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness or Injury or Any Other Medical Condition

<input type="checkbox"/>	<input type="checkbox"/>	For Females ONLY	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses		
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy		Last Menstrual Period

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. LIST ALL SURGERIES \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

14. LIST ALL HOSPITALIZATIONS \_\_\_\_\_ 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): \_\_\_\_\_  
 Have you passed an oxygen tolerance test?  
 Air \_\_\_\_\_ Yes  No   
 Mixed Gases \_\_\_\_\_  
 Saturation \_\_\_\_\_ Name of Diving School \_\_\_\_\_

21. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS  
 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
Gas Embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oxygen Toxicity	<input type="checkbox"/>	<input type="checkbox"/>	_____
CO <sub>2</sub> Toxicity	<input type="checkbox"/>	<input type="checkbox"/>	_____
CO Toxicity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Sinus Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Drum Rupture	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	Details
Lung Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	_____
Near Drowning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asphyxiation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vertigo (Dizziness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nitrogen Narcosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: \_\_\_\_\_ Name of Physician who performed your last exam \_\_\_\_\_  
 For what company or organization were you last examined? \_\_\_\_\_ Address of Physician \_\_\_\_\_  
 City, State \_\_\_\_\_

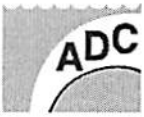
24. Have you ever had any of the following? If so, give approximate date:

Yes	No	Give Date	Yes	No	Give Date
<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Condition Studies _____
<input type="checkbox"/>	<input type="checkbox"/>	Longbone Series _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Function Studies _____
<input type="checkbox"/>	<input type="checkbox"/>	Back (Spine) X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	Audiogram _____
<input type="checkbox"/>	<input type="checkbox"/>	ENG _____	<input type="checkbox"/>	<input type="checkbox"/>	EKG _____
<input type="checkbox"/>	<input type="checkbox"/>	EEG _____	<input type="checkbox"/>	<input type="checkbox"/>	Exercise (Stress) EKG _____
<input type="checkbox"/>	<input type="checkbox"/>	EMG _____	<input type="checkbox"/>	<input type="checkbox"/>	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 Page 2 of 4



# Association of Diving Contractors International

## 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 <input type="checkbox"/> Yes <input type="checkbox"/> No			
NORMAL		ABNORMAL		Check each item in appropriate column (enter NE for Not Evaluated)			
				REMARKS			
				17. Head, Face, Scalp			
				18. Neck			
				19. Eyes			
				20. Fundus			
				21. Ears – General (internal and external canal)			
				22. Eustachian Tube Function			
				23. Tympanic Membrane			
				24. Nose (Septal Alignment)			
				25. Sinuses			
				26. Mouth and Throat			
				27. Chest			
				28. Lungs			
				29. Heart (Thrust, Size, Rhythm, Sounds)			
				30. Pulses (Equality, etc.)			
				31. Vascular System (Varicosities, etc.)			
				32. Abdomen and Viscera			
				33. Hernia (All Types)			
				34. Endocrine System			
				35. G-U System			
				36. Upper Extremities (Strength, ROM)			
				37. Lower Extremities (Except Feet)			
				38. Feet			
				39. Spine			
				40. Skin, Lymphatics			
				41. Anus and Rectum			
				42. Sphincter Tone			
				43. Pelvic Exam			

### NEUROLOGICAL EXAMINATION

#### 44. 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	Glossopharyngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

#### 45. 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			

#### 46. CEREBELLAR FUNCTION

	0	1	2	3	4
Ataxia					
Tremor (intention)					
Finger to Nose					
Heel to Shin (Sliding)					

#### 47. MUSCLE

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

#### TONE

	Normal	Abnormal

#### 48. PROPIOCEPTION

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

#### 49. NYSTAGMUS

	Present	Absent
End Point Lateral Gaze		
Pathological		

#### 50. SENSATION

	Normal	Abnormal
Hot		
Cold		

	Normal	Abnormal
Sharp		
Soft		

Two Point Discrimination	
Normal	
Abnormal	

#### 51. RHOMBERG

Absent	
Present	

