

# SMITH DIVING

## MEDICAL HISTORY INFORMATION FORM

*To be submitted for all scuba training courses*

Medical History Statement: I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ears and sinus are essential for my safety and well being. I hereby confirm that to the best of my knowledge my circulatory and respiratory systems and body air spaces are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness for the rigors of diving. Write Y (yes) or N (no) next to each of the following and explain under remarks any yes answers.

<input type="checkbox"/> Behavioral health problems	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Contact lenses
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dental plates
<input type="checkbox"/> Agoraphobia	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Physical disability
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Back problems	<input type="checkbox"/> Serious injury
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Back/spinal surgery	<input type="checkbox"/> Over 40 years old
<input type="checkbox"/> Ear or hearing problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Trouble equalizing pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> HIV positive
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Regular medication
<input type="checkbox"/> Severe hay fever	<input type="checkbox"/> Hernia	<input type="checkbox"/> Drug allergies
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Alcohol or drug abuse
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Rejected from any activity for medical reasons
<input type="checkbox"/> Angina	<input type="checkbox"/> Hospitalized	<input type="checkbox"/> Any medical problem not listed
<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Pregnant	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Motion sickness	

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications you are presently taking: \_\_\_\_\_

\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

I am a minor and my parent or guardian has signed below.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If at any time during your dive training your medical condition changes notify your NAUI Instructor immediately and Complete a new NAUI medical history information form for inclusion in your student file.