

HSA INTERNATIONAL

MEDICAL HISTORY FORM

STUDENT'S NAME _____ BIRTH DATE ____/____/____
FIRST MIDDLE LAST MONTH DAY YEAR
ADDRESS _____
CITY/STATE/PROVINCE _____ POSTAL CODE _____
COUNTRY _____ TELEPHONE _____ EMAIL _____
HEIGHT _____ WEIGHT _____ DISABILITY TYPE _____
HSA INSTRUCTOR NAME _____ HSA INSTRUCTOR # _____

Medical History Questionnaire

The purpose of this questionnaire is to determine if you should be examined by a doctor prior to participating in a diver-training course. A positive response to a question does not necessarily disqualify you; it simply means you must seek approval from a doctor before engaging in diving activities.

<input type="checkbox"/> Do you take prescription medication?	<input type="checkbox"/> Heart problems* _____
<input type="checkbox"/> Are you, or could you be, Pregnant?*	<input type="checkbox"/> Heart or blood vessel surgery
<input type="checkbox"/> Are you over 45 years of age?	<input type="checkbox"/> High blood pressure medication
<input type="checkbox"/> Asthma, or wheezing with exercise*	<input type="checkbox"/> Pulmonary embolus*
<input type="checkbox"/> Seizure disorder, epilepsy or convulsions*	<input type="checkbox"/> Bleeding problems _____
<input type="checkbox"/> Frequent colds, sinusitis or bronchitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Severe hay fever or allergy	<input type="checkbox"/> Back problems _____
<input type="checkbox"/> Pneumothorax, collapsed lung*	<input type="checkbox"/> Back or spinal surgery
<input type="checkbox"/> Lung disease	<input type="checkbox"/> History of Surgery, description _____
<input type="checkbox"/> Chest surgery	_____
<input type="checkbox"/> Blackouts	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Motion sickness
<input type="checkbox"/> Ear or sinus problems	<input type="checkbox"/> Head injury with loss of consciousness
<input type="checkbox"/> Recurring Headaches or Migraines	<input type="checkbox"/> Drug or alcohol treatment in past 5 years
<input type="checkbox"/> Decompression sickness or diving accident	<input type="checkbox"/> History of Tracheotomy, why? _____
<input type="checkbox"/> Behavioral health, mental or psychological (panic attacks, fear of open/ closed spaces)	<input type="checkbox"/> Physical disability (amputee, paraplegia, etc.)

PHYSICIAN

This person has applied for training, or is currently certified to engage in the sport of Scuba Diving. Based on a physical examination, your opinion of the applicants Medical Fitness for scuba diving is requested.

Physician's impression:

I find no Medical conditions that I consider incompatible with Scuba Diving.

I am UNABLE to recommend this person for Scuba Diving.

Remarks _____

_____, M.D. Date of Medical Exam ____/____/____
Physician's Signature

Physician Name _____ Telephone _____

Address _____, City _____, State _____ Zip _____