MEDICAL HISTORY

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in diving, SUB or snorkeling activities. A positive response to a question does not necessarily disqualify you from the activity. A positive response means that there is a pre-existing condition that may affect your safety while diving, using the SUB or snorkeling and you must seek the advice of your physician.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer YES. If any of these items apply to you, we may request that you consult with your physician prior to participating in scuba diving. **You must fill out each question in full (YES OR NO). An "N" or a "Y", blanks or lines are not acceptable and will hold up your check-in.**

Please list any allergies you may have:	
Do you regularly take prescription or non-prescription medications (except birth control or hormones)? Please list the names of the medications, dosage and what condition they are for.	

_____ Could you be pregnant?

_____ Do you have a family history of heart attacks or strokes?

_____ Have you ever had a heart attack?

_____ Have you ever had a stroke?

_____ Do you have allergy induced Asthma?

_____ Do you have exercise, anxiety or stress induced Asthma?

_____ Do you regularly use an asthma inhaler or take oral medication for asthma?

Have you ever had or do you currently have...

_____ Frequent or severe attacks of hay fever or allergy?

_____ Frequent colds, sinusitis or bronchitis?

_____ Any form of lung disease?

_____ Pneumothorax (collapsed lung)?

_____ History of chest surgery?

_____ Claustrophobia or agoraphobia (fear of closed or open spaces)?

_____ Behavioral health problems?

_____ Epilepsy, seizures or convulsions or take medication to prevent them?

_____ Recurring migraine headaches or take medication to prevent them?

_____ Do you frequently suffer from motion sickness (seasick, carsick, etc?)

_____ History of diving accidents or decompression illness?

_____ History of recurrent back problems following surgery, injury or fracture?

_____ Inability to perform moderate exercise?

_____ History of diabetes?

_____ History of ear or sinus surgery?

_____ History of any heart disease?

_____ Angina or heart surgery or blood vessel pressure?

_____ History of high blood pressure, or take medications to control it?

_____ History of ear disease, hearing loss or problems with balance?

_____ History of problems equalizing ears with airplane or mountain travel?

_____ History of bleeding or other blood disorders?

_____ History of any type of hernia?

_____ History of ulcers or ulcer surgery?

_____ History of colostomy?

_____ History of drug or alcohol abuse?

_____ History of blackouts or fainting (full/partial loss of consciousness)?

The information I have provided about my medical history is accurate to the best of my knowledge.

Signature _____ Date From: _____ Date To: _____

_____ Please print your name clearly

_____ Witness