NOAA 56-58
(6-03)

# UBC DIVING MEDICAL HISTORY REPORT

_____, _____ _____

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| 1. NAME (Last, First M.I.) | | | 2. SOCIAL INSURANCE NUMBER | 3. DATE OF EXAM |
|---|---|---|---|---|
| 4.M.S.P NUMBER | | 5.DEPARTMENT | | 6. WORK PHONE |
| 7. DATE OF BIRTH | 8. AGE | 9. SEX ☐ MALE ☐ FEMALE | 10. WORK ADDRESS | |
| 11. CURRENT MEDICATION & DOSAGE | | | 12. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS | |
| 13. PRESENT HEALTH | | | | |
| 14. ALLERGIES (List All) | | | 15. RATING OR SPECIALTY OF EXAMINER | |

## 16. PAST/CURRENT MEDICAL HISTORY *(Do you have or have you ever had the following)*

| CHECK EACH ITEM | YES | NO | CHECK EACH ITEM | YES | NO | CHECK EACH ITEM | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Trouble with your ears, including ruptured ear drum, difficulty clearing your ears, or surgery | | | Heart disease or high cholesterol | | | Surgery of any kind (if yes, explain below) | | |
| | | | Diabetes mellitus | | | Hospitalization for any reason (if yes, explain below) | | |
| Decompression sickness, embolism, or other diving malady | | | Anatomical heart abnormalities including patent foramen ovale, valve problems, etc | | | Take any medications (list above) | | |
| Depression, anxiety, claustrophobia, or any other psychiatric disorder | | | Heart rhythm problems | | | Allergic to any medications, foods, or environmental factors (list above) | | |
| | | | Need for a pacemaker | | | | | |
| Eye surgery | | | Difficulty with exercise | | | Smoke (if yes, how much) | | |
| Loss of consciousness for any cause | | | High blood pressure | | | Drink alcoholic beverages (how much) | | |
| Epilepsy, or other seizures, convulsions, or fits | | | Collapsed lung | | | Family history of high cholesterol | | |
| Stroke or any neurological deficit | | | Asthma | | | Family history of heart disease or stroke | | |
| Recurring neurologic disorders, including transient ischemic attacks | | | Exposed to a person with tuberculosis (TB), or have persistent cough, sweats, or weight loss | | | Family history of diabetes | | |
| | | | | | | Family history of asthma | | |
| Aneurysms or bleeding in the brain | | | Tuberculosis or positive TB test | | | Substance abuse, including alcohol | | |
| Trouble with dizziness | | | Other lung diseases | | | Use any illegal substances | | |
| Head injury | | | Pregnancy<br>Date of last menstrual period: | | | Thyroid trouble | | |
| Disorders of the blood or easy bleeding | | | | | | Bone, joint, or other deformity | | |

17. EXPLAIN IN DETAIL "YES" ANSWERS TO ANY OF THE ABOVE QUESTIONS

***I certify that the above answers and information represent a true, accurate, and complete description of my medical history.***

| 18. TYPED OR PRINTED NAME OF PATIENT | 19. SIGNATURE | 20. DATE |
|---|---|---|

21. EXAMINER SUMMARY OF DEFECTS

| 22. TYPED OR PRINTED NAME OF EXAMINER | 23. SIGNATURE | 24. DATE |
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