Diving Center Fornells

Family name, Name :.....

Address :..... City : .....

Country :.....

Tel number : ..... email : .....

Date of birht : ..... Passeport : .....

MEDICAL HISTORY. To the participant :

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

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 must request that you consult with a physician prior to participating in scuba diving. Your instructor will supply you with an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician

___ Could you be pregnant, or are you attempting to become pregnant?

___ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial)

___ Are you over 45 years of age and can answer YES to one or more of the following?

- currently smoke a pipe, cigars or cigarettes
- have a high cholesterol level
- have a family history of heart attack or stroke
- are currently receiving medical care
- high blood pressure
- diabetes mellitus, even if controlled by diet alone

Have you ever had or do you currently have…

___ Asthma, or wheezing with breathing, or wheezing with exercise?

___ Frequent or severe attacks of hayfever or allergy?

___ Frequent colds, sinusitis or bronchitis?

___ Any form of lung disease?

___ Pneumothorax (collapsed lung)?

___ Other chest disease or chest surgery?

___ Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?

___ Epilepsy, seizures, convulsions or take medications to prevent them?

___ Recurring complicated migraine headaches or take medications to prevent them?

___ Blackouts or fainting (full/partial loss of consciousness)?

___ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?

___ Dysentery or dehydration requiring medical intervention?

___ Any dive accidents or decompression sickness?

___ Inability to perform moderate exercise (example: walk 1.6 km/ one mile within 12 mins.)?

___ Head injury with loss of consciousness in the past five years?

___ Recurrent back problems?

___ Back or spinal surgery?

___ Diabetes?

___ Back, arm or leg problems following surgery, injury or fracture?

___ High blood pressure or take medicine to control blood pressure?

___ Heart disease?

___ Heart attack?

___ Angina, heart surgery or blood vessel surgery?

___ Sinus surgery?

___ Ear disease or surgery, hearing loss or problems with balance?

___ Recurrent ear problems?

___ Bleeding or other blood disorders?

___ Hernia?

___ Ulcers or ulcer surgery ?

___ A colostomy or ileostomy?

___ Recreational drug use or treatment for, or alcoholism in the past five years?

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Date : ..... Signature :.....