

Flying After Diving Calibration Medical History Form

<small>GAUGE</small> New Participant
<small>GAUGE</small> Updated form
Date Participating: ____/____/____
DUMC Med. History #: _____
To get a DUMC Med. History# call 684-3911

Name _____	Date _____	
Address _____	Date of Birth _____	
	SSN _____	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height _____	Weight _____ Race _____
Phone#s Home _____	Work _____	Cell _____
E-mail _____		
Marital Status _____	Employment _____	
Emergency Contact/Next of Kin Name: _____		
Phone _____		
Insurance Information _____		

Past Medical History

Please answer the following questions, providing additional information where necessary.

General

How would you describe your current physical condition?

Excellent Good Average Poor

Have you seen a physician in the last year? If yes, why? _____

Date of last physician visit _____

Identify personal M.D. _____

Are you currently taking any medications? _____

Which medications have you taken in the last 30 days? _____

Do you have any medication or environmental allergies? _____

Are you current on your immunizations? _____

When was your last tetanus shot? _____

Do you suffer from any permanent or chronic disease? _____

Have you experienced a recent weight change? _____

Have you ever had any surgery or been advised to have surgery? _____

If so, when and why? _____

Have you ever suffered a major injury? _____

Have you been hospitalized in the last 3 yrs? If so, when and why? _____

Please describe the nature and dates of any self treated illnesses in last 6 mos.

Have you ever had a heat stroke or other heat-related illness? _____

Is there any history of a reaction to anesthesia in yourself or your family? _____

Physical Activity Survey

Compared to a year ago, how much regular physical activity do you currently get? (check one)

Much less Somewhat less About the same Somewhat more Much more

For the last three months, have you been exercising on a regular basis? Yes No

What type of exercise or physical activity do you currently participate in? (e.g. cycling, walking, swimming, weight lifting, gardening, etc.)

What type of exercise or physical activity have you regularly done in the past? (e.g. cycling, walking, swimming, weight lifting, gardening, etc.)

On the average, how many days per week do you exercise?

How long do you usually exercise each time?

How hard do you exercise on a scale of 1 to 5 (1 being easy, and 5 being hard)?

Do you ever check your heart rate (pulse) to determine how hard you are exercising? Yes No

If so, at what heart rate do you typically exercise? beats per minute

Check the appropriate number (0-7) which best describes your activity level or the previous month.

- 0 avoid walking or exertion, e.g. always use elevator, drive whenever possible instead of walking
- 1 walk for pleasure, routinely use stairs, occasionally exercise sufficiently to cause heavy breathing or perspiration
Participate regularly in recreation or work requiring modest physical activity e.g. golf, horseback riding, bowling or yard work for:
- 2 10-60 minutes per week
- 3 over 1 hour per week.
Participate regularly in heavy physical activity e.g. running, cycling swimming, tennis, basketball, soccer:
- 4 1 mile per week or less than 30 minutes per week in comparable physical activity
- 5 1 to 5 miles per week or 30 to 60 minutes per week in comparable physical activity
- 6 5 to 10 miles per week or 1 to 3 hours per week in comparable physical activity
- 7 Over 10 miles per week or over 3 hours per week in comparable physical activity

Ophthalmology

Do you have impaired vision in one or both eyes? Right Left

Do you require vision correction? Glasses Hard contact lenses Soft contacts lenses

Have you had corrective vision surgery? Do you have any type of color blindness?

Have you ever had a detached retina? Have you ever had a temporary loss of vision?

Do you have a prosthetic eye? Have you had any other sort of eye trouble?

Dental

Do you currently have an active tooth problem? Have you had severe tooth or gum problems?

Do you have any bridgework or dentures? Did you wear braces?

ENT

Have you ever had dizzy spells? Have you ever ruptured your ear drum?

Have you ever had trouble clearing your ear or sinuses on airplanes or in the mountains?

Do you have problems with sinusitis? recurrent sinus infections? motion sickness?

frequent colds or allergies? ringing in ears? hearing loss? persistent hoarseness?

hay fever? broken nose or deviated septum? Do you wear a hearing aid?

Have you ever had ear surgery? Have you had any other ear, nose, sinus, or throat trouble?

Cardiovascular

What's your cholesterol, if known? _____
Have you ever been told you have high blood pressure or hypertension? _____
Have you ever had chest pain or pressure? _____ at rest? _____ or with exertion? _____
Have you ever experienced palpitations or fluttering sensations in your chest? _____
Have you had shortness of breath at rest or unusual shortness of breath with exertion? _____
Ever blacked out or experienced dizziness or faintness with exercise? _____
Do you have a heart murmur or heart rhythm problems? _____
Were you ever diagnosed with rheumatic fever? _____ Do you have leg cramps with exercise? _____
Have you had any other sort of heart or blood vessel problems? _____

Pulmonary

Do you have asthma? _____
Do you have problems with wheezing? _____ shortness of breath? _____ chronic cough? _____
Have you ever had a collapsed lung (pneumothorax)? _____ or had a chest tube? _____
Have you ever been told you have tuberculosis (TB) _____ pleurisy _____ cysts in lung? _____
Have you ever coughed up blood? _____
Have you experienced exercise induced coughing or wheezing _____ nighttime coughing _____
or coughing while breathing cold air? _____
Have you had any other sort of breathing trouble or chronic lung problem? _____

Gastrointestinal

Any difficulty with swallowing? _____ Do you have frequent indigestion or heartburn _____
or abdominal cramping or stomach pains? _____
Have you ever had gall bladder trouble or gallstones? _____ stomach, liver or intestinal trouble? _____
Have you ever been diagnosed with gastritis _____ ulcers _____ hepatitis, _____ or jaundice? _____
Do you have frequent or chronic diarrhea _____ or constipation? _____
Have you ever had black, bloody or tarry stools? _____
Have you ever had a hernia _____ or hemorrhoids? _____
Have you had any other sort of digestive tract problem? _____

Genitourinary

Have you had recurrent bladder infections _____ frequent urination _____ or painful urination? _____
Have you ever lost bladder control (incontinence) _____ or had persistent sexual difficulties? _____
Have you had kidney or bladder stones? _____
Ever been told you had sugar or protein in your urine? _____
Had any other sort of urinary or reproductive tract problems (females see next section)? _____

Gynecologic (females only)

Could you now be pregnant? Yes _____ No _____
Are you considering or planning a pregnancy in the near future? Yes _____ No _____
Do you have regular periods? _____ When was your last menstrual period? _____
Have you recently been, or are you currently taking birth control pills? _____
Are you up to date with regard to your Pap Smear _____ Breast exams _____ Mammogram? _____
Have you ever treated for a female disorder? _____
Have you experienced a recent change in menstrual pattern? _____

Hematologic

Have you ever had excessive bleeding after an injury or tooth extraction? _____
Do you have sickle cell trait or disease? _____
Have you ever been told you had anemia or low blood counts? _____
Have you recently donated blood? _____
Do you have any other bleeding problem or blood disorder? _____

Endocrine

Have you ever been told you had diabetes or abnormal blood sugar? _____
Are you aware of unusually excessive thirst, increasing appetite, or frequent urination? _____
Ever had a goiter or other type of thyroid disease? _____

Musculoskeletal

Do you have problems with arthritis? _____ rheumatism? _____ bursitis? _____
Do you have any bone, joint, or other deformity? _____
Describe any injuries involving broken bones or serious joint injury? _____

Have you ever worn a cast? _____
Do you have a trick shoulder, elbow, or knee? _____
Have you ever had a serious back injury? _____
Do you have frequent backaches? _____ Back pain limiting activity _____
Wear brace or support? _____
Do you have other joint pain limiting activity? _____ Swollen painful joints? _____
Have you ever had a serious neck injury? _____ Do you have neck pain limiting activity? _____
Do you have leg cramps with exercise? _____ Muscle problems? _____ Foot problems? _____

Neurologic

Have you had a head injury associated with unconsciousness or memory loss? _____
Have you ever had seizures, fits convulsions or epilepsy? _____
Do you suffer with any of the following nervous system problems:
migraine headaches? _____ tension headaches? _____ sinus headaches? _____
other frequent or severe headaches? _____
sleep or alertness disorder (narcolepsy, sleepwalking, sleep apnea) _____
double vision? _____ motion sickness? _____ neuritis? _____ bell's palsy? _____
persistent or unexpected numbness, weakness or paralysis? _____
fainting/dizzy spells/other loss of consciousness? _____ skull fracture? _____
memory loss, amnesia? _____ numbness or tingling of any part of the body? _____
carpal tunnel syndrome? _____ sciatica? _____

Oncologic

Have you ever had any type of cancer or tumor? _____

Psychiatric

Have you ever been diagnosed with or suffered from the following:
depression? _____ hallucinations? _____ agoraphobia? _____
speech disorder (stutter or stammer)? _____ learning disorder? _____
reading disorder? _____ anxiety or nervous tension? _____ insomnia? _____
Have you had any other type of nerve problems? _____
Have you ever contemplated or attempted suicide? _____

Do you have any special powers not found in others? _____
Have you been treated for any other mental condition? _____

Dermatologic

Do you have any type of skin disease? _____

Infectious Disease

Have you ever had TB (tuberculosis) or have you lived with a someone suffering from TB? _____
Have you been diagnosed with HIV or AIDS? _____
Have you ever had a transfusion? _____
Have you ever used intravenous drugs or had sexual relations with an intravenous drug user? _____
Have you ever had rheumatic fever? _____ hepatitis? _____ jaundice? _____ scarlet fever? _____
erysipelas? _____ any type of VD (syphilis, gonorrhoea, herpes)? _____

Dysbarism

Are you a SCUBA diver? _____
Have you ever had "the bends" or any other decompression illness? _____
Have you ever had any other problems or accidents while diving? _____
Any history of mountain sickness or other altitude related illness? _____
Do you have trouble clearing your ears or sinuses on planes or while driving in mountains? _____
List any environmentally stressful or hazardous activities you've engaged in. (e.g., scuba diving, flying, climbing, caisson work, etc.) _____

Family History

Are you aware of any of the following in your family: heart attack? _____ sudden death? _____
heart trouble? _____ high blood pressure? _____ stroke? _____ seizures? _____
diabetes? _____ cancer? _____ allergies or hay fever? _____ migraine headache? _____
schizophrenia? _____
Are there any other serious or unusual family illnesses? _____

Social History

Do you use tobacco at this time? _____ Have you done so in the past? _____
How many packs per day for how long? _____
How much alcohol do you typically consume in a week? _____
Have you ever been dependent on alcohol or drugs? _____
Have you ever lost a job or been refused employment due to inability to assume certain positions?
or inability to perform certain motions? _____ other medical reasons? _____
Have you been denied life insurance? _____
Have you ever been rejected or discharged from military service for a medical reason? _____
In the past, have you applied for disability or a pension? _____
Are you aware of any other condition that might influence your ability to participate in this experiment?

Do you have any questions for a doctor at this time with regard to this protocol or your fitness to participate?

Examiner's comments:

Physician: _____ Date: _____

I certify to the best of my knowledge that the information on this Medical History form is correct:

Participant Signature: _____ Date: _____