

USN Flying After Diving Medical History Form

<input type="checkbox"/> Updated form
Date Participating: ____/____/____
DUMC Med. History #: _____
To get a DUMC Med. History# call 684-3911

Name _____ Date _____
Address _____ Date of Birth _____
_____ SSN _____

Gender ___M___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 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 _____

Circle 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: claustrophobia? _____
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, gonorrhea, 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 _____