

Association of Diving Contractors International MEDICAL HISTORY FORM

Employe	er		Job Title	Э				Date
1.	Last Name	First Name	Middle Name	Date of Birt	h	3. Ge	ender	4. SSN or PP#
						Male	Female	
5.	Address	6. City		7.State	8.Zip code	9. Phone	Number	
10. Emergency contact person – Relationship – Address – Telephone Number					11. Cell Phon	e Number		

Epii Cor Disi Los Sev Unc Faii We Col Eye Hea Ear Far Per Diff Nos Airv Hay Che Hea Abr Hea Car For Irreq	Invulsions or Seizures Ilepsy Incussion or Head Injury Incussion Sickness Incorrected Sylvers Incorrected Sylvers Incustry Incus	Yes No	Cardiac Angiogram or ECHO PFO Repair High Blood Pressure Asthma or Wheezing Coughing up Blood Tuberculosis Shortness of Breath Chronic Cough Pneumothorax Lung Disease or Surgery Stomach Trouble or Ulcers Stomach Bleeding Frequent Indigestion Jaundice Liver Disease or Hepatitis Rectal Bleeding / Blood in Stools Hemorrhoids (Piles) Gas Pains Crohn's Disease / Ulcerative Colitis Rupture or Hernia Kidney Disease Kidney Stones Protein, Sugar or Blood in Urine Joint Pain / Arthritis Back Strain or Injury Spine Problems	Yes	No	Herniated Disc or Sciatica Shoulder Injury Elbow Injury Arm/wrist/hand Injury Hip / Leg / Ankle Injury Knee Injury or "Trick Knee" Foot Trouble or Injuries Dislocations Swollen Joints Broken Bones or Fractures Muscle Disease or Weakness Numbness or Paralysis Sleep Disorders Diabetes Goiter or Thyroid Disease Blood Disease Anemia: Sickle Cell or Other Skin Rash or Disease Staph Infections Tumor or cancer Claustrophobia Mental Illness / Depression / Anxiety Nervous Breakdown Any Sexually Transmitted Disease Contagious Disease Other Illness or Injury or Any Other Medical Condition
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For Irreq EASE EXPLAIN THE	Females ONLY		Painful Menses			Other Illness or Injury or Any Other Medical Condition
Irre						
EASE EXPLAIN THE	guidi Monoco		riogranoy			Last Menstrual Period
	DETAILS OF EACH ITE	M CHECKED Y	/ES			
LIST ALL SURGERI	IES					YEAR
LIST ALL HOSPTAL	IZATIONS					
LIST ALL INJURIES	3					<u> </u>
LIST ALL MEDICAT	IONS, PRESCRIPTION C	OR OVER THE	COUNTER			
ANSWER THE FOL						
ery Item Checked Yes	LOWING QUESTIONS:					

Do you Have any physical defects or any partial disabilities?	Have you ever resigned, been terminated, or changed jobs For medical reasons?
Have you ever been rejected or rated for insurance, employment, License, or armed forces for health reasons?	Have you ever been dismissed from employment because of Excess use of drugs or alcohol?
Have you ever had illnesses, injuries, or lost time accidents from Any work that you have done?	Do you have any allergies or reactions to food, chemicals, Drugs, insect lings, or marine life?
Have you been advised to have a surgical operation or medical Treatment that has not been done?	Are you presently under the care of a physician? Give Physician's name and address on the next page?

COMMENTS:		

	sician is:	Name						_
		Address						_
		City, State						_
		Phone Number						_
9. DIVING HISTOR	Y How L	ong have you been c	ommercial d	living?				_
	Surfac	ce Air Diving History					Saturation Diving Hist	ory
Maximum Depth Surf	face Air		Helio	x Yes	No		Maximum Depth	
Maximum Depth Surf	face Mixed Gas		Trimix	Yes	No			
ongest Bottom Time	e Air		Nitro	x Yes	No		Maximum Duration (d	ays)
ongest Bottom Time	e Mixed Gas							
22. IN DIVING HAVE	YOU HAD A HIST	ORY OF: (Provide de	tails of dates	and severit	y)			
	Yes No						Yes No	
Gas Embolism					Lung Squeeze			
Oxygen Toxicity					Near Drowning			
CO2 Toxicity					Asphyxiation			
CO Toxicity					Vertigo (Dizzine	ss)		
Ear / Sinus Squeeze					Pneumothorax			
Ear Drum Rupture					Nitrogen Narcosi	6		
Deafness					Loss of Conscio	ousness		
23. Have you been in	nvolved in a diving a	accident (decompress	ion sickness	or others) s	ince your last phy	sical exa	mination?	Yes No
Date of last physical	examination:			Name	of Physician who	performe	ed your last exam	
For what company or	r organization were	you last examined?				Address o	of Physician	
						City, State	е	
24. Have you ever ha	ad any of the followi	ng? If so, give approx	imate date:					
'es No				Yes	No			Give Date
	Chest X-Ray				I	Nerve Co	ondition Studies	
	Longbone Series				1	Pulmonar	ry Function Studies	
	Longbone Series					Audiograr		
	Back (Spine) X-R	ay			•	-tudiogi ai	m	
		ay				EKG	m	
	Back (Spine) X-R				I	≣KG	m (Stress) EKG	
	Back (Spine) X-R	ay			1	≣KG		
	Back (Spine) X-R ENG EEG	ay			1	EKG Exercise		
25.Physician Remark	Back (Spine) X-R ENG EEG EMG	ay			1	EKG Exercise		
25.Physician Remark	Back (Spine) X-R ENG EEG EMG	ay			1	EKG Exercise		
≀5.Physician Remark	Back (Spine) X-R ENG EEG EMG	ay			1	EKG Exercise		
!5.Physician Remark	Back (Spine) X-R ENG EEG EMG	ay			1	EKG Exercise		
25.Physician Remark	Back (Spine) X-R ENG EEG EMG	ay			1	EKG Exercise		
	Back (Spine) X-R ENG EEG EMG			LOUDDINE		EKG Exercise ((Stress) EKG	
CERTIFY THAT I H. JNDERTAND THAT	Back (Spine) X-R ENG EEG EMG ks:	HE FOREGOING INF	G FACTS CA	ALLED FOR	BY ME AND THA ABOVE MAY BE	EKG Exercise (MRI AT IT IS 1 CAUSE	(Stress) EKG FRUE AND COMPLETE FOR REFUSAL OF EM	PLOYMENT OR SEPARATION FROM T
CERTIFY THAT I H. JNDERTAND THAT COMPANY. I AUTHO	Back (Spine) X-R ENG EEG EMG KS: IAVE REVIEWED T I LEAVING OUT OR ORIZE ANY OF TH	HE FOREGOING INF	G FACTS CA	ALLED FOR CLINICS MEI	BY ME AND THA ABOVE MAY BE NTIONED ABOV	EKG Exercise (MRI AT IT IS 1 CAUSE E TO FUI	(Stress) EKG FRUE AND COMPLETE FOR REFUSAL OF EM	PLOYMENT OR SEPARATION FROM T
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GRETNA LOCATION:
107 Wall Blvd. • Suite A
Gretna, Louisiana 70056
PHONE: 504.433.5077 • FAX: 504.433.5077

MARRERO LOCATION
4475 Westbank Expressway • Suite A
Marrero, Louisiana 70072
PHONE: 504.347.8471 • IAX: 504.340.2885

EMPLOYEE INFORMATION:

Company:		Facility: Employee #:					
Date of Birth:	Sex:	Male	Female	Shift:	Day	Night	
AAO-HNS Medical Referral Criteria – 1996:							
Have you recently experienced pain in the either Have you recently experienced a draining ear? Have you recently experienced dizziness? Have you recently experienced severe tinnitus (r. Have you recently experienced fluctuating hearing Have you recently experienced sudden hearing Have you recently experienced ear fullness or distributed in the Have you recently had problems wearing hearing	inging)? ng loss? oss? scomfort?	?			Right – Right – Right – Right – Right –	Left – Both - No Left – Both - No Yes - No	
Examiner only: (Examiner only) Subject has visible wax or object (Examiner only) Subject should be referred.	t in ear					Yes - No Yes - No	
Medical History: Have you ever served in the military? Have you ever been to a doctor for an ear related Have you ever had a severe head injury? Have you ever had ear surgery? Have you ever had an ear injury? Have you ever had measles? Have you ever had mumps? Have you ever had kidney disease? Have you ever had scarlet fever? Have you ever had meningitis? Do you have diabetes? Do you have high blood pressure? Do you have an existing hearing problem? Do you have frequent ear infections? Do you wear a hearing aid? Do you participate in loud activities (music, motor Do you currently us prescription of over the coun Are you currently suffering from allergies? Does any of your immediate family have hearing	rcycle)? ter drugs?				Right – Right –	Yes - No Left - Both - No Yes - No Left - Both - No Left - Both - No Yes - No Left - Both - No Yes - No	
Do you have any other comments on the health of	of your hear	ing?					



GRETNA LOCATION:
107 Wall Blvd. • Suite A
Gretna, Louisiana 70056
PHONE: 504.433.5077 • FAX: 504.433.5077

Please print:

MARRERO LOCATION
4475 Westbank Expressway • Suite A
Marrero, Louisiana 70072
PHONE: 504.347.8471 • FAX: 504.340.2885

West Jefferson Industrial Medicine

NAME:		AGE:	
ADDRESS:			
CITY:	STATE	ZIP CODE:	
PHONE #()		SEX:	
DATE OF BIRTH:	SOCIA	AL SECURITY#	
COMPANY:			
CONSENT FOR SERVICES			
I hereby consent to medical eva West Jefferson Industrial Medicine.	lluation, testing,	, and/or treatment to me by the staff of	:
I authorize West Jefferson Indus necessary to carry out treatment, payme		to disclose Protected Health Informations re operations.	n
I understand that my treatment of these services or treatment are the reinformation.	•	be denied by refusal to sign this conse party who will require disclosure of	∍nt
I hereby release West Jefferson arising from this disclosure.	n Industrial Medi	licine and its employees from any liabil	ity
Signature		Date	