Association of Diving Contractors International
MEDICAL HISTORY FORM

Employer	Job Title			Date
1. Last Name First Name Middle Name	2. Date of Birth		3. Gender ☐ Male ☐ Female	4. SSN or PP#
5. Address 6. City	7.State	8.Zip code	9. Phone Number	
10. Emergency contact person – Relationship – Address – Telephone Number			11. Cell Phone Number	

12. MEDICAL HISTORY: have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
☐	☐	Convulsions or Seizures	☐	☐	Cardiac Angiogram or ECHO	☐	☐	Herniated Disc or Sciatica
☐	☐	Epilepsy	☐	☐	PFO Repair	☐	☐	Shoulder Injury
☐	☐	Concussion or Head Injury	☐	☐	High Blood Pressure	☐	☐	Elbow Injury
☐	☐	Disabling Headaches	☐	☐	Asthma or Wheezing	☐	☐	Arm/wrist/hand Injury
☐	☐	Loss of Balance / Dizziness	☐	☐	Coughing up Blood	☐	☐	Hip / Leg / Ankle Injury
☐	☐	Severe Motion Sickness	☐	☐	Tuberculosis	☐	☐	Knee Injury or “Trick Knee”
☐	☐	Unconsciousness	☐	☐	Shortness of Breath	☐	☐	Foot Trouble or Injuries
☐	☐	Fainting Spells	☐	☐	Chronic Cough	☐	☐	Dislocations
☐	☐	Wear Contacts / Glasses	☐	☐	Pneumothorax	☐	☐	Swollen Joints
☐	☐	Color Vision Defect	☐	☐	Lung Disease or Surgery	☐	☐	Broken Bones or Fractures
☐	☐	Eye Surgery	☐	☐	Stomach Trouble or Ulcers	☐	☐	Muscle Disease or Weakness
☐	☐	Hearing Loss	☐	☐	Stomach Bleeding	☐	☐	Numbness or Paralysis
☐	☐	Ear Disease or Injury	☐	☐	Frequent Indigestion	☐	☐	Sleep Disorders
☐	☐	Ear Surgery	☐	☐	Jaundice	☐	☐	Diabetes
☐	☐	Perforated Eardrum	☐	☐	Liver Disease or Hepatitis	☐	☐	Goiter or Thyroid Disease
☐	☐	Difficulty Clearing	☐	☐	Rectal Bleeding / Blood in Stools	☐	☐	Blood Disease
☐	☐	Nose Bleed	☐	☐	Hemorrhoids (Piles)	☐	☐	Anemia: Sickle Cell or Other
☐	☐	Airway Obstruction	☐	☐	Gas Pains	☐	☐	Skin Rash or Disease
☐	☐	Hay Fever or Allergies	☐	☐	Crohn’s Disease / Ulcerative Colitis	☐	☐	Staph Infections
☐	☐	Chest Pain	☐	☐	Rupture or Hernia	☐	☐	Tumor or cancer
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Rheumatic Fever	☐	☐	Kidney Stones	☐	☐	Mental Illness / Depression / Anxiety
☐	☐	Heart Attack	☐	☐	Protein, Sugar or Blood in Urine	☐	☐	Nervous Breakdown
☐	☐	Abnormal Heart Rhythm	☐	☐	Joint Pain / Arthritis	☐	☐	Any Sexually Transmitted Disease
☐	☐	Heart Disease	☐	☐	Back Strain or Injury	☐	☐	Contagious Disease
☐	☐	Cardiac Stent or Angioplasty	☐	☐	Spine Problems	☐	☐	Other Illness or Injury or Any Other Medical Condition

For Females ONLY				
Irregular Menses	☐	Painful Menses	☐	
		Pregnancy	☐	Last Menstrual Period

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES _____

13. LIST ALL SURGERIES _____ YEAR

14. LIST ALL HOSPTALIZATIONS

15. LIST ALL INJURIES

16. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

17. ANSWER THE FOLLOWING QUESTIONS:

Every Item Checked Yes Must Be Fully Explained Below

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: _____

18. My Personal Physician is: Name _____

Address _____

City, State _____

Phone Number _____

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19. DIVING HISTORY How Long have you been commercial diving?_____

Surface Air Diving History

Maximum Depth Surface Air _____

Maximum Depth Surface Mixed Gas _____

Longest Bottom Time Air _____

Longest Bottom Time Mixed Gas _____

Heliox Yes ☐ No ☐

Trimix Yes ☐ No ☐

Nitrox Yes ☐ No ☐

Saturation Diving History

Maximum Depth _____

Maximum Duration (days) _____

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22. IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)

	Yes	No			Yes	No	
Gas Embolism	☐	☐	_____	Lung Squeeze	☐	☐	_____
Oxygen Toxicity	☐	☐	_____	Near Drowning	☐	☐	_____
CO2 Toxicity	☐	☐	_____	Asphyxiation	☐	☐	_____
CO Toxicity	☐	☐	_____	Vertigo (Dizziness)	☐	☐	_____
Ear / Sinus Squeeze	☐	☐	_____	Pneumothorax	☐	☐	_____
Ear Drum Rupture	☐	☐	_____	Nitrogen Narcosis	☐	☐	_____
Deafness	☐	☐	_____	Loss of Consciousness	☐	☐	_____

23. Have you been involved in a diving accident (decompression sickness or others) since your last physical examination? ☐ Yes ☐ No

Date of last physical examination: _____ Name of Physician who performed your last exam _____

For what company or organization were you last examined? Address of Physician _____

_____ City, State _____

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24. Have you ever had any of the following? If so, give approximate date:

Yes	No			Yes	No		Give Date
☐	☐	Chest X-Ray	_____	☐	☐	Nerve Condition Studies	_____
☐	☐	Longbone Series	_____	☐	☐	Pulmonary Function Studies	_____
☐	☐	Back (Spine) X-Ray	_____	☐	☐	Audiogram	_____
☐	☐	ENG	_____	☐	☐	EKG	_____
☐	☐	EEG	_____	☐	☐	Exercise (Stress) EKG	_____
☐	☐	EMG	_____	☐	☐	MRI	_____

25.Physician Remarks:

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRITP OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

_____ _____

Date Signature

West Jefferson Industrial Medicine, L.L.C.
Your Company....Our Priority
www.wjimed.com

GRETNA LOCATION:
107 Wall Blvd. • Suite A
Gretna, Louisiana 70056
PHONE: 504.433.5070 • FAX: 504.433.5077

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

EMPLOYEE INFORMATION:

Company: _____ Facility: _____ Status: Active or Pre-Employment

SSN: _____ Employee #: _____ Hire Date: _____

Name: _____ Job Title: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Shift: ☐ Day ☐ Night

AAO-HNS Medical Referral Criteria – 1996:

Have you recently experienced pain in the either ear?	Right – Left – Both - No
Have you recently experienced a draining ear?	Right – Left – Both - No
Have you recently experienced dizziness?	Right – Left – Both - No
Have you recently experienced severe tinnitus (ringing)?	Right – Left – Both - No
Have you recently experienced fluctuating hearing loss?	Right – Left – Both - No
Have you recently experienced sudden hearing loss?	Right – Left – Both - No
Have you recently experienced ear fullness or discomfort?	Right – Left – Both - No
Have you recently had problems wearing hearing protection?	Yes - No

Examiner only:

(Examiner only) Subject has visible wax or object in ear	Yes - No
(Examiner only) Subject should be referred.	Yes - No

Medical History:

Have you ever served in the military?	Yes - No
Have you ever been to a doctor for an ear related problem?	Right – Left – Both - No
Have you ever had a severe head injury?	Yes - No
Have you ever had ear surgery?	Right – Left – Both - No
Have you ever had an ear injury?	Right – Left – Both - No
Have you ever had measles?	Yes - No
Have you ever had mumps?	Yes - No
Have you ever had kidney disease?	Yes - No
Have you ever had scarlet fever?	Yes - No
Have you ever had meningitis?	Yes - No
Do you have diabetes?	Yes - No
Do you have high blood pressure?	Yes - No
Do you have an existing hearing problem?	Yes - No
Do you have frequent ear infections?	Right – Left – Both - No
Do you shoot guns of hunt?	Yes - No
Do you wear a hearing aid?	Right – Left – Both - No
Do you participate in loud activities (music, motorcycle)?	Yes - No
Do you currently us prescription of over the counter drugs?	Yes - No
Are you currently suffering from allergies?	Yes - No
Does any of your immediate family have hearing problems?	Yes - No

Do you have any other comments on the health of your hearing? _____

_____
Subject Date

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Gretna, Louisiana 70056
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West Jefferson Industrial Medicine

Please print:

NAME: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE:_____

PHONE #(_____) _____ SEX: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

COMPANY: _____

CONSENT FOR SERVICES

I hereby consent to medical evaluation, testing, and/or treatment to me by the staff of West Jefferson Industrial Medicine.

I authorize West Jefferson Industrial Medicine to disclose Protected Health Information necessary to carry out treatment, payment or healthcare operations.

I understand that my treatment or service may be denied by refusal to sign this consent if these services or treatment are the request of a third party who will require disclosure of information.

I hereby release West Jefferson Industrial Medicine and its employees from any liability arising from this disclosure.

_____ _____

Signature Date