VIKING DIVING SERVICES, INC
MEDICAL HISTORY FORM

DATE

LAST NAME	FIRST NAME	MI	S.S.N.
DATE OF BIRTH		SEX	
		( ) M ( ) F	
ADDRESS			
PHONE #		CELL #	
SINGLE ( )	MARRIED ( )	SPOUSE NAME	
NEXT OF KIN		RELATIONSHIP	
ADDRESS			
PHONE #		CELL #	

MY PRESENT STATE OF HEALTH IS:

( ) GOOD ( ) FAIR ( ) POOR

LIST ALL SURGERIES, SERIOUS ILLNESS OR INJURIES	YEAR

PLEASE EXPLAIN THE DETAILS OF ALL CHECKES YES

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MY PERSONAL PHYSICIAN IS: ______________________________

Address : ______________________________

Phone # ______________________________

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ANSWER THE FOLLOWING QUESTIONS: Explain all items checked YES

	YES	NO
Do you have any physical defects or any partial disabilities?		
Do you have any conditions that may require special work assignments?		
Have you ever be rejected for insurance/employment/armed forces for health reasons?		
Have you ever had ill affects from any work that you have done?		
Are you taking any type of medication including Patent medicines?		
Have you ever been advised to have a surgical operation or medical treatment and declined?		
Have you ever resigned, been terminated or changed jobs for medical reasons?		
Have you ever been dismissed because of excess use of alcohol /drugs?		
Do you presently us marihuana, LSD, narcotics or controlled substances?		
Do you have any allergies/reactions to food, chemicals, drugs, or insect stings?		
Are you presently under the care of a physician? If yes list the information below.		
Name:		
Address:		
Phone #:		

HAVE YOU EVER HAD OR BEEN TREATED FOR:

YES	NO		YES	NO	
		Eye trouble (not glasses)			Elbow injury
		Ear trouble			Foot trouble
		Epilepsy			Irregular menses
		Appendicitis			Jaundice
		Arthritis			Kidney trouble
		Anemia: sickle cell			Knee injury
		Abnormal heart Rhythm			Lung trouble
		Airway obstruction			Liver disease
		Asthma			Nose bleed
		Heart trouble			Nervous breakdown
		Heart attack			Painful menses
		Heart murmur			Paralysis
		High blood pressure			Perforated Eardrum
		Head Injury			Rheumatic fever
		Convulsion			Rectal pains
		Color vision defect			Rectal bleeding
		Chest pain			Rheumatism
		Coughing of breath			Shortness of breath
		Chronic Cough			Stomach trouble
		Blood disease			Shoulder injury
		Broken bones			Swollen ankles
		Blood in urine			Skin rash
		Back strain			Tuberculosis
		Diabetes			Thyroid trouble
		Disc problems			Tumor or cancer
		Dislocations			Urinary trouble
		Disabling headaches			Varicose veins

PLEASE EXPLAIN THE DETAILS OF ALL CHECKED YES

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____
____

How long have you been diving? ___________ Max. Depth: Surface Air ___________

Surface mixed gases ___________

Longest bottom time: Air ___________ Have you made any saturation dive? ( ) Yes ( ) No

Mixed gases ___________ Gas mix: Heliox Trimex Nllrex

Max. Depth ___________ Total duration (days) ______

Have you past and oxygen tolerance test? __________ Name of company / school ______________________

Number of Decompression Incidents:

Bend: pain only ________________ Neurological ________________

Serious Symptoms: chokes _______________ Inner Ear __________________

List any residuals: ____

IN DIVING HAVE YOU HAD A HISTORY OF:

Gas Embolism ________ Lung Squeeze ________ Oxygen Toxicity _________

Near drowning ________ CO2 Toxicity ________ Asphyxiation ___________

CO Toxicity __________ Vertigo (dizziness)______ Ear Squeeze ____________

Deafness ____________ Ear Drum Rupture ______ Nitrogen Narcosis ________

Los of consciousness _________ Strums Squeeze _________

If you answered YES to any of the above, provide details.

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____
____
____

Have you been involved in a diving accident (decompression sickness or other) ( ) YES ( ) NO

If so, provide details

____
____
____

Date of last physical examination ____

For what company or organization were you examined last? ____

I CERTIFY THAT I HAVE REVIEWED THE PRESENT INFORMATION SUPPLIED BU ME AND THAT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE ____ DATE___________________________