

NOAA DIVING - ANNUAL MEDICAL HISTORY REPORT

ALL NOAA-certified divers must complete and submit this form each year to the NOAA Diving Center by MARCH 1st. Failure to submit this form may result in NOAA diving certification suspension. Forms may be faxed to the Diving Center at (206) 526-6506, or mailed to NDC, 7600 Sand Point Way NE, Seattle, WA 98115.

1. NAME (Last, First M.I.)			2. SOCIAL SECURITY NUMBER	3. WORK PHONE	
4. WORK ADDRESS			5. AGENCY		
			6. DIVING UNIT		
7. DATE OF BIRTH	8. AGE	9. SEX U MALE U FEMALE		10. STATEMENT OF PRESENT HEALTH	
11. CURRENT MEDICATION & DOSAGE (Note if new medication or if dosage has changed)			12. ALLERGIES (List All)		

13. PAST/CURRENT MEDICAL HISTORY (Do you have or have you ever had the following)

INSTRUCTIONS: Check "Yes" and explain any item listed below that has **changed** in the last year or since you last submitted a Medical History Form to the NOAA Diving Center (Otherwise, check "No"). Include associated dates with any items explained. A physician's signature is not required for this form.

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Trouble with your ears, including ruptured ear drum, difficulty clearing your ears, or surgery			Heart disease or high cholesterol			Surgery of any kind (if yes, explain below)		
			Diabetes mellitus			Hospitalization for any reason (if yes, explain below)		
Decompression sickness, embolism, or other diving malady			Anatomical heart abnormalities including patent foramen ovale, valve problems, etc			Take any medications (list above)		
			Heart rhythm problems			Allergic to any medications, foods, or environmental factors (list above)		
Depression, anxiety, claustrophobia, or any other psychiatric disorder			Need for a pacemaker			Smoke (if yes, how much)		
			Difficulty with exercise			Drink alcoholic beverages (how much)		
Eye surgery			High blood pressure			Family history of high cholesterol		
Loss of consciousness for any cause			Collapsed lung			Family history of heart disease or stroke		
Epilepsy, or other seizures, convulsions, or fits			Asthma			Family history of diabetes		
Stroke or any neurological deficit			Exposed to a person with tuberculosis (TB), or have persistent cough, sweats, or weight loss			Family history of asthma		
						Substance abuse, including alcohol		
Recurring neurologic disorders, including transient ischemic attacks			Tuberculosis or positive TB test			Use any illegal substances		
Aneurysms or bleeding in the brain			Other lung diseases			Thyroid trouble		
Trouble with dizziness			Pregnancy			Bone, joint, or other deformity		
Head injury			Date of last menstrual period:					
Disorders of the blood or easy bleeding								

14. EXPLAIN IN DETAIL "YES" ANSWERS TO ANY OF THE ABOVE QUESTIONS

I certify that the above answers and information represent a true, accurate, and complete description of my medical history.

15. TYPED OR PRINTED NAME OF DIVER	16. SIGNATURE	17. DATE
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