

Post Dive Health

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Date Sent:	Date Return:					
All questions contained i	in this questionnaire a	re strictly confid	dential and will	become part of	your	dive log and medical record.
Name: (Last, First, M.I.)				□ M □ F		DOB:
Department Assignment:	☐ Sheriff ☐	1 Police	☐ Fire Dept.	☐ Emergen	су М	gt.
	☐ Emergency Me	dical	☐ Other:			
Personal Physican:	Date of last physical exam:					
	PER	SONAL HEA	ALTH HISTO	RY		
Have you ever had:	☐ Measles	☐ Mun				
	☐ Chickenpox		umatic Fever	☐ Polio		
	☐ Tetanus			☐ Pneumoni	a	
Immunizations and dates:	☐ Hepatitis					
	☐ Influenza			☐ MMR (Measles, Mumps, Rhubella		Mumps, Rhubella
List any medical issues you s	uffer that have beer	n diagnosed b	y doctors.			
Year		Reasc	on			Hospital
If you have been hospitalized	d for any reason, ple	ase explain.				
Year		Reaso	on			Hospital
Have you ever be de blee de	ensfusion?					D Vas D Ma
Have you ever had a blood tr						☐ Yes ☐ No
Do you have any allergies to	e of Drug	T			Pose	tion
IName	e oi Diug				Reac	LIOH

		L HEALTH HISTORY Cont.						
	dications you currently take, including: pre							
N	lame of Drug	Strength	Frequency Taken					
	•							
	HEALTH HAB	ITS AND PERSONAL SAFETY						
	ALL QUESTIONS CONTAINED IN THIS QUESTION	NNAIRE ARE OPTIONAL AND WILL BE KEPT	STRICTLY CONFID	ENTIAL.				
Exercise:	☐ Sedentary (No exercise) ☐ Mild exerc	ise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or	r recreation, less than 4x/week for 30 n	nin.)					
	☐ Regular vigorous exercise (i.e., work or red	creation 4x/week for 30 minutes)						
Diet:	Are you dieting? ☐ Yes ☐ No							
	If yes, are you on a physician prescribed die	et? 🔲 Yes 🗖 No		☐ None ☐ Coffee				
	Number of meals you eat in an average day	1	□ Tea					
	Rank Salt Intake		☐ Cola # Cups/cans per day					
		☐ High ☐ Medium ☐ Low						
	Rank Fat Intake	☐ High ☐ Medium ☐ Low						
Alcohol:	Do you drink alcohol? ☐ Yes ☐ No Are you concerned about the amount you drink? ☐ Yes ☐ No							
	If yes, what kind?							
	Have you considered stopping? □ Yes □	No Have you ever experienced b	Have you ever experienced blackouts?					
	Are you prome to binge drinking? 🗖 Yes 🗆	1 No Do you drive after drinking?	? • Yes • No					
Tobacco:	Do you use tobacco? ☐ Yes ☐ No	☐ Cigarettes - #/perday	☐ Chew -	#/perday				
	D Pipe - #/perday ☐ Cigars - #/p			, ,				
Drugs:	Do you currently use recreational/street dr	rugs? □ Yes □ No						
	Have you ever given yourself street drugs v	with a needle? ☐ Yes ☐ No						
Sex:	Are you sexually active? ☐ Yes ☐ No If yes, are you trying for a pregnancy ☐ Yes ☐ No							
	If not trying for a pregnancy list contraceptive/barrier method used:							
	Any discomfort with intercourse? ☐ Yes ☐ No							
	Illness related to the Human Immunodefic Risk factors for this illness include intravend Would you like to speak with your provider	ous drug use and unprotected sexual i	ntercourse.	ıblic health problem.				

Personal	Do you live alone	Do you live alone? ☐ Yes ☐ No							
Safety:	Do you live alone?								
Do you have vision/hearing loss? \(\textstyle \text{Yes} \(\textstyle \text{No} \)									
	Do you have an Advance Directive/Living Will?								
	Would you like information on the preparation of these? ☐ Yes ☐ No								
	Physical and/or mental abuse have also become major public health issues in this country.								
	This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes No								
Mental	ls stress a major p	roblem for you? 🗖 Yes 🗖 No							
Health:	Do you feel depressed? ☐ Yes ☐ No								
	Do you panic when stressed? ☐ Yes ☐ No								
	Do you have problems with eating or your appetite? Yes No								
	Do you cry frequently? Yes No								
Have you ever attempted suicide? ☐ Yes ☐ No									
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No									
	Do you have trouble sleeping? □ Yes □ No								
	Have you ever been to a counselor? □ Yes □ No								
		Wome	en Only						
Age at onse	t of menstruation:		Urinary tract, bladder or kidney infections w/in last year? $\ \square$ Yes $\ \square$ No						
Date of last	menstruation:		Any blood in your urine? ☐ Yes ☐ No						
Period every	/da	ays	Any problems with control of urination? $\ \square$ Yes $\ \square$ No						
Heavy period	Heavy periods, irregularity, spotting, pain, or discharge? $\ \square$ Yes $\ \square$ No			Any hot flashes or sweating at night? $\ \square$ Yes $\ \square$ No					
Number of pregnancies			Do you have menstrual tension, pain, bloating, irritability,						
Number of live births			or other symptoms at or around time of period?						
Pregnant/breastfeeding? ☐ Yes ☐ No			Experienced any recent breast tenderness, lumps or nipple discharge?						
Have you ha	ad a D&C, hysterectom	ny or Cesarean? ☐ Yes ☐ No	Date of last pap and rectal exam?						
		Men	ı Only						
•	Do you usually get up to urinate during the night? $\ \square$ Yes $\ \square$ No			Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Yes ☐ No					
•	If yes, # of times Do you feel pain or burning with urination? ☐ Yes ☐ No			Problems emptying your bladder completely? ☐ Yes ☐ No					
ŕ			'	Any difficulty with erection or ejaculation? ☐ Yes ☐ No					
Any blood in your urine? ☐ Yes ☐ No Burning discharge from your penis? ☐ Yes ☐ No			Any testicle pain or swelling? ☐ Yes ☐ No						
Has the force of your urination decreased? ☐ Yes ☐ No			Date of last prostate and rectal exam?						
Thus the fore	e or your armation de	163 2 110							
	Check if you have, or	Other F have had, any symptoms in the fo	Problems ollowing areas to a	significant degree and brief	ly explain.				
☐ Skin	☐ Chest/Heart	☐ Head/Neck	☐ Back	☐ Weight	☐ Recent changes				
☐ Ears	☐ Intestinal	□ Nose	☐ Bladder	☐ Ability to sleep	in energy level				
☐ Throat	☐ Bowel	☐ Other pain/discomfort:	☐ Lungs	☐ Circulation					