



Post Dive Health

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Date Sent:	Date Return:
All questions contained in this questionnaire are strictly confidential and will become part of your dive log and medical record.	
Name: (Last, First, M.I.)	<input type="checkbox"/> M <input type="checkbox"/> F
DOB:	
Department Assignment:	
<input type="checkbox"/> Sheriff <input type="checkbox"/> Police <input type="checkbox"/> Fire Dept. <input type="checkbox"/> Emergency Mgt. <input type="checkbox"/> Emergency Medical <input type="checkbox"/> Other:	
Personal Physican:	Date of last physical exam:

PERSONAL HEALTH HISTORY

Have you ever had:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rhubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio
Immunizations and dates:	<input type="checkbox"/> Tetanus _____ <input type="checkbox"/> Pneumonia _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Chickenpox _____ <input type="checkbox"/> Influenza _____ <input type="checkbox"/> MMR (Measles, Mumps, Rhubella) _____

List any medical issues you suffer that have been diagnosed by doctors.

Year	Reason	Hospital

If you have been hospitalized for any reason, please explain.

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Do you have any allergies to medications:

Name of Drug	Reaction

Personal Safety:

- Do you live alone? Yes No
- Do you have frequent falls? Yes No
- Do you have vision/hearing loss? Yes No
- Do you have an Advance Directive/Living Will? Yes No
- 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 Health:

- Is stress a major problem for you? Yes No
- 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

Women Only

- Age at onset of menstruation: _____
- Date of last menstruation: _____
- Period every _____ days
- Heavy periods, irregularity, spotting, pain, or discharge? Yes No
- Number of pregnancies _____
- Number of live births _____
- Pregnant/breastfeeding? Yes No
- Have you had a D&C, hysterectomy or Cesarean? Yes No
- Urinary tract, bladder or kidney infections w/in last year? Yes No
- Any blood in your urine? Yes No
- Any problems with control of urination? Yes No
- Any hot flashes or sweating at night? Yes No
- Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No
- Experienced any recent breast tenderness, lumps or nipple discharge? Yes No
- Date of last pap and rectal exam? _____

Men Only

- Do you usually get up to urinate during the night? Yes No
- If yes, # of times _____
- Do you feel pain or burning with urination? Yes No
- Any blood in your urine? Yes No
- Burning discharge from your penis? Yes No
- Has the force of your urination decreased? Yes No
- Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No
- Problems emptying your bladder completely? Yes No
- Any difficulty with erection or ejaculation? Yes No
- Any testicle pain or swelling? Yes No
- Date of last prostate and rectal exam? _____

Other Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- | | | | | | |
|---------------------------------|--------------------------------------|---|----------------------------------|---|---|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Weight | <input type="checkbox"/> Recent changes in energy level |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Nose | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ability to sleep | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bowel | <input type="checkbox"/> Other pain/discomfort: | <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | |