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.) ❑ M ❑ F	**DOB:**
Department Assignment: ❑ Sheriff ❑ Police ❑ Fire Dept. ❑ Emergency Mgt. ❑ Emergency Medical ❑ Other:	
Personal Physican:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Have you ever had:	❑ Measles ❑ Mumps ❑ Rhubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio
Immunizations and dates:	❑ Tetanus _____ ❑ Pneumonia _____ ❑ Hepatitis _____ ❑ Chickenpox _____ ❑ Influenza _____ ❑ 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 HEALTH HISTORY Cont.

List any medications you currently take, including: prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name of Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise: ❑ Sedentary (No exercise) ❑ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
❑ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
❑ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ❑ Yes ❑ No
If yes, are you on a physician prescribed diet? ❑ Yes ❑ No
Number of meals you eat in an average day?
Rank Salt Intake ❑ High ❑ Medium ❑ Low
Rank Fat Intake ❑ High ❑ Medium ❑ Low

Caffeine: ❑ None
❑ Coffee
❑ Tea
❑ Cola
Cups/cans per day
_____

Alcohol:
Do you drink alcohol? ❑ Yes ❑ No
If yes, what kind? _____
Have you considered stopping? ❑ Yes ❑ No
Are you prome to binge drinking? ❑ Yes ❑ No
Are you concerned about the amount you drink? ❑ Yes ❑ No
How many drinks per week? _____
Have you ever experienced blackouts? ❑ Yes ❑ No
Do you drive after drinking? ❑ Yes ❑ No

Tobacco: Do you use tobacco? ❑ Yes ❑ No ❑ Cigarettes - #/perday _____ ❑ Chew - #/perday _____
❑ Pipe - #/perday _____ ❑ Cigars - #/perday _____ ❑ # of years _____

Drugs:
Do you currently use recreational/street drugs? ❑ Yes ❑ No
Have you ever given yourself street drugs 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 Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.
Would you like to speak with your provider about your risk of this illness? ❑ Yes ❑ No

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.

❑ Skin	❑ Chest/Heart	❑ Head/Neck	❑ Back	❑ Weight	❑ Recent changes in energy level
❑ Ears	❑ Intestinal	❑ Nose	❑ Bladder	❑ Ability to sleep	
❑ Throat	❑ Bowel	❑ Other pain/discomfort:	❑ Lungs	❑ Circulation	