



2.4.3 ADCI MEDICAL HISTORY AND EXAMINATION FORMS



Association of Diving Contractors International  
MEDICAL HISTORY FORM

Employer			Job Title		Date	
1. Last Name	First Name	Middle Name	2. Email Address		3. Date of Birth	4. Gender
					5. Last 4 No. of SSN	
6. Address (Number, Street)			7. City	8. State	9. Zip Code	10. Area Code - Phone Number ( )
11. Emergency Contact Person - Relationship - Address - Telephone Number						12. Cell Phone Number ( )

13. MEDICAL HISTORY: Have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Angiogram or ECHO	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	PFO Repair	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Injury
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arm/wrist/hand Injury
<input type="checkbox"/>	<input type="checkbox"/>	Disabling Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Hip/Leg/Ankle Injury
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury or "Trick Knee"
<input type="checkbox"/>	<input type="checkbox"/>	Severe Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble or Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints
<input type="checkbox"/>	<input type="checkbox"/>	Wear Contacts/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones or Fractures
<input type="checkbox"/>	<input type="checkbox"/>	Color Vision Defect	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease or Stones	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disease or Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Goiter or Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Perforated Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Clearing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding/Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	Anemia: Sickle Cell or Other
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash or Disease
<input type="checkbox"/>	<input type="checkbox"/>	Airway Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains	<input type="checkbox"/>	<input type="checkbox"/>	Staph Infections
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness/Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Protein, Sugar or Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Any Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Strain or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Prior Military Service
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Spine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness or Injury or Any Other Medical Condition
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc or Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> For Females ONLY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	Last Menstrual Period _____		

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES \_\_\_\_\_

14. LIST ALL SURGERIES

YEAR

15. LIST ALL HOSPITALIZATIONS

YEAR

16. LIST ALL INJURIES

YEAR

17. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

18. ANSWER THE FOLLOWING QUESTIONS:

Every Item Checked Yes Must Be Fully Explained Below	YES	NO		YES	NO
Do you have any physical defects or any partial disabilities?			Have you ever resigned, been terminated, or changed jobs for medical reasons?		
Have you ever been rejected or rated for insurance, employment, license, or armed forces for health reasons?			Have you ever been dismissed from employment because of excess use of drugs or alcohol?		
Have you ever had illnesses, injuries, or lost time accidents from any work that you have done?			Do you have any allergies or reactions to food, chemicals, drugs, insect stings, or marine life?		
Have you been advised to have a surgical operation or medical treatment that has not been done?			Are you presently under the care of a physician? Give physician's name and address on the next page.		

COMMENTS: \_\_\_\_\_



19. My Personal Physician is: Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State \_\_\_\_\_  
 Phone Number \_\_\_\_\_

20. DIVING HISTORY How long have you been commercial diving? \_\_\_\_\_

Surface Air Diving History		Saturation Diving History	
Maximum Depth Surface Air _____		Heliox Yes <input type="checkbox"/> No <input type="checkbox"/>	Maximum Depth _____
Maximum Depth Surface Mixed Gas _____		Trimix Yes <input type="checkbox"/> No <input type="checkbox"/>	Maximum Duration (Days) _____
Longest Bottom Time Air _____		Nitrox Yes <input type="checkbox"/> No <input type="checkbox"/>	
Longest Bottom Time Mixed Gas _____			

21. DIVING EXPERIENCE (Number of years experience):  
 Name of Diving School \_\_\_\_\_  
 Air \_\_\_\_\_  
 Mixed Gases \_\_\_\_\_  
 Saturation \_\_\_\_\_

22. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS  
 If None put 0 (Zero) List any residuals  
 Bends, pain only \_\_\_\_\_  
 Bends, neurological \_\_\_\_\_  
 Chokes \_\_\_\_\_  
 Inner ear \_\_\_\_\_

23. IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)

Yes	No	Details	Yes	No	Details
<input type="checkbox"/>	<input type="checkbox"/>	Gas Embolism _____	<input type="checkbox"/>	<input type="checkbox"/>	Lung Squeeze _____
<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Near Drowning _____
<input type="checkbox"/>	<input type="checkbox"/>	CO <sub>2</sub> Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Asphyxiation _____
<input type="checkbox"/>	<input type="checkbox"/>	CO Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (Dizziness) _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear/Sinus Squeeze _____	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Drum Rupture _____	<input type="checkbox"/>	<input type="checkbox"/>	Nitrogen Narcosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness _____	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness _____

24. Have you been involved in a diving accident (decompression sickness or others) since your last physical examination?  Yes  No

25. Date of last physical examination: \_\_\_\_\_ Name of Physician who performed your last exam \_\_\_\_\_  
 For what company or organization were you last examined? \_\_\_\_\_ Address of Physician \_\_\_\_\_  
 \_\_\_\_\_ City, State \_\_\_\_\_

26. Have you ever had any of the following? If so, give approximate date:  

Yes	No	Give Date	Yes	No	Give Date
<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Function Studies _____
<input type="checkbox"/>	<input type="checkbox"/>	Longbone Series _____	<input type="checkbox"/>	<input type="checkbox"/>	Audiogram _____
<input type="checkbox"/>	<input type="checkbox"/>	Back (Spine) X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	EKG _____
<input type="checkbox"/>	<input type="checkbox"/>	MRI _____	<input type="checkbox"/>	<input type="checkbox"/>	Exercise (Stress) EKG _____

27. Physician Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

Date \_\_\_\_\_ Signature \_\_\_\_\_



**Association of Diving Contractors International  
PHYSICAL EXAMINATION FORM**

Employer	Date	Date of Birth	Age
1. Last Name First Name		Middle Name	2. Last 4 No. of SSN or PASSPORT No.
3. Height (inches)	4. Weight (pounds)	5. Body Fat (%) (Optional)	6. BMI (Optional)
7. Temperature	8. Blood Pressure /	9. Pulse/Rhythm	10. General Appearance/Hygiene
11. Build		12. Distant Vision: R. 20/ _____ Corr. to 20/ _____ L. 20/ _____ Corr. to 20/ _____	
13. Near Vision: Jaeger R. 20/ _____ L. 20/ _____		Near Vision Corrected R. 20/ _____ L. 20/ _____	
14. Color Vision (Test Performed and Results)			
15. Field of Vision (Degrees) R. _____ ° L. _____ °		16. Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No	
NORMAL	ABNORMAL	Check each item in appropriate column (enter NE for Not Evaluated)	
		REMARKS	
		17. Head, Face, Scalp	
		18. Neck	
		19. Eyes	
		20. Ears – General (internal and external canal)	
		21. Eustachian Tube Function	
		22. Tympanic Membrane	
		23. Nose (Septal Alignment)	
		24. Sinuses	
		25. Mouth and Throat	
		26. Chest	
		27. Lungs	
		28. Heart (Thrust, Size, Rhythm, Sounds)	
		29. Pulses (Equality, etc.)	
		30. Vascular System (Varicosities, etc.)	
		31. Abdomen and Viscera	
		32. Hernia (All Types)	
		33. Endocrine System	
		34. G-U System	
		35. Upper Extremities (Strength, ROM)	
		36. Lower Extremities (Except Feet)	
		37. Feet	
		38. Spine	
		39. Skin, Lymphatics	
		40. Anus and Rectum	
		41. Sphincter Tone	

**NEUROLOGICAL EXAMINATION**

**42. CRANIAL NERVES**

		NORMAL	ABNORMAL	NE
I	Olfactory			
II	Optic			
III	Oculomotor			
IV	Trochlear			
V	Trigeminal			
VI	Abducens			

		NORMAL	ABNORMAL	NE
VII	Facial			
VIII	Auditory			
IX	Glossopharyngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

**43. REFLEXES**

		DEEP TENDON				PATHOLOGICAL				SUPERFICIAL			
		Left		Right		Left		Right		Present	Absent	NE	
		0	1	2	3	4	Present	Absent	Present	Absent			
Triceps											Upper Abdomen		
Biceps											Lower Abdomen		
Patella											Cremasteric		
Achilles													

**44. CEREBELLAR FUNCTION**

	0	1	2	3	4
Ataxia					
Tremor (intention)					
Finger to Nose					
Heel to Shin (Sliding)					
Rapidly Alternating Movements					

**45. MUSCLE**

	1	2	3	4	5
Right Upper Extremity					
Left Upper Extremity					
Right Lower Extremity					
Left Lower Extremity					

	Normal	Abnormal

**46. PROPIOCEPTION**

	Left		Right	
	Normal	Abnormal	Normal	Abnormal
Joint Position Sense				
Stereognosis				
Vibratory Sensation				

**47. NYSTAGMUS**

	Present	Absent
End Point Lateral Gaze		
Pathological		

**48. SENSATION**

	Normal	Abnormal
Hot		
Cold		

**49. ROMBERG**

	Normal	Abnormal
Two Point Discrimination		
Normal		
Abnormal		





## DIVER CERTIFICATION BOARD OF CANADA

## OCCUPATIONAL DIVER'S CERTIFICATE OF MEDICAL FITNESS

This certificate of medical fitness is granted as a result of having passed a comprehensive occupational diver's medical fitness examination conducted by a physician knowledgeable and competent in diving medicine.

### DIVER INFORMATION

Diver's Last Name (please print)	First Name(s)	Social Insurance Number	Date of Birth (dd/month/yyyy)
Mailing Address	City	Province/State	Postal/Zip Code
Home Telephone Number	Cellular/Business Phone Number		

### OCCUPATIONAL DIVER'S MEDICAL FITNESS EXAMINATION RESULTS

Classification <input type="checkbox"/> Fit <input type="checkbox"/> Unfit <input type="checkbox"/> Fit with restrictions (specify restrictions)		
Date of examination (day/month/year)	Date of medical certification (day/month/year)	
Expiry date of medical fitness certificate (must be renewed at least every 2 years up to age 39 years and annually from age 40 onwards or MORE FREQUENTLY IF CLINICALLY INDICATED) <input type="checkbox"/> 2 years from date of examination <input type="checkbox"/> 1 year from date of examination <input type="checkbox"/> Other (Specify expiry date _____ (dd/month/yyyy))		
Physician's name (please print clearly)	Physician's Signature	
Mailing Address	City	Postal Code
Telephone Number	Cellular/Business Phone Number	