Divers and Drivers Medical Company, PLLC
PO Box 2529, Poulsbo, WA 98370

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	
☐	☐	Convulsions or Seizures	☐	☐	Cardiac Angiogram or ECHO	☐	☐	Shoulder Injury
☐	☐	Epilepsy	☐	☐	PFO Repair	☐	☐	Elbow Injury
☐	☐	Concussion or Head Injury	☐	☐	High Blood Pressure	☐	☐	Arm/wrist/hand Injury
☐	☐	Disabling Headaches	☐	☐	Asthma or Wheezing	☐	☐	Hip/Leg/Ankle Injury
☐	☐	Loss of Balance/Dizziness	☐	☐	Coughing up Blood	☐	☐	Knee Injury or "Trick Knee"
☐	☐	Severe Motion Sickness	☐	☐	Tuberculosis	☐	☐	Foot Trouble or Injuries
☐	☐	Unconsciousness	☐	☐	Shortness of Breath	☐	☐	Dislocations
☐	☐	Fainting Spells	☐	☐	Chronic Cough	☐	☐	Swollen Joints
☐	☐	Wear Contacts/Glasses	☐	☐	Pneumothorax	☐	☐	Broken Bones or Fractures
☐	☐	Color Vision Defect	☐	☐	Lung Disease or Surgery	☐	☐	Varicose Veins
☐	☐	Eye Disease or Injury	☐	☐	Gallbladder Disease or Stones	☐	☐	Muscle Disease or Weakness
☐	☐	Eye Surgery	☐	☐	Stomach Trouble or Ulcers	☐	☐	Numbness or Paralysis
☐	☐	Hearing Loss	☐	☐	Stomach Bleeding	☐	☐	Sleep Disorders
☐	☐	Ear Disease or Injury	☐	☐	Frequent Indigestion	☐	☐	Diabetes
☐	☐	Ear Surgery	☐	☐	Jaundice	☐	☐	Goiter or Thyroid Disease
☐	☐	Perforated Eardrum	☐	☐	Liver Disease or Hepatitis	☐	☐	Blood Disease
☐	☐	Difficulty Clearing	☐	☐	Rectal Bleeding/Blood in Stools	☐	☐	Anemia: Sickle Cell or Other
☐	☐	Nose Bleed	☐	☐	Hemorrhoids (Piles)	☐	☐	Skin Rash or Disease
☐	☐	Airway Obstruction	☐	☐	Gas Pains	☐	☐	Staph Infections
☐	☐	Hay Fever or Allergies	☐	☐	Crohn's Disease/Ulcerative Colitis	☐	☐	Tumor or Cancer
☐	☐	Chest Pain	☐	☐	Rupture or Hernia	☐	☐	Claustrophobia
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Mental Illness/Depression/Anxiety
☐	☐	Rheumatic Fever	☐	☐	Kidney Stones	☐	☐	Nervous Breakdown
☐	☐	Heart Attack	☐	☐	Protein, Sugar or Blood in Urine	☐	☐	Any Sexually Transmitted Disease
☐	☐	Abnormal Heart Rhythm	☐	☐	Joint Pain/Arthritis	☐	☐	Contagious Disease
☐	☐	Heart Disease	☐	☐	Back Strain or Injury	☐	☐	Prior Military Service
☐	☐	Cardiac Stent or Angioplasty	☐	☐	Spine Problems	☐	☐	Other Illness or Injury or Any Other Medical Condition
			☐	☐	Herniated Disc or Sciatica			
		For Females ONLY	☐	☐	Painful Menses			
☐	☐	Irregular Menses	☐	☐	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: _____

Reviewed by: _____ **Date** _____

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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

Maximum Depth Surface Air _____
Maximum Depth Surface Mixed Gas _____
Longest Bottom Time Air _____
Longest Bottom Time Mixed Gas _____

Saturation Diving History

Heliox Yes ☐ No ☐
Trimix Yes ☐ No ☐
Nitrox Yes ☐ No ☐

Maximum Depth _____
Maximum Duration (Days) _____

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
Gas Embolism	☐	☐		Lung Squeeze	☐	☐	
Oxygen Toxicity	☐	☐		Near Drowning	☐	☐	
CO_2 Toxicity	☐	☐		Asphyxiation	☐	☐	
CO Toxicity	☐	☐		Vertigo (Dizziness)	☐	☐	
Ear/Sinus Squeeze	☐	☐		Pneumothorax	☐	☐	
Ear Drum Rupture	☐	☐		Nitrogen Narcosis	☐	☐	
Deafness	☐	☐		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
☐	☐	Chest X-Ray		☐	☐	Pulmonary Function Studies	
☐	☐	Longbone Series		☐	☐	Audiogram	
☐	☐	Back (Spine) X-Ray		☐	☐	EKG	
☐	☐	MRI		☐	☐	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**

Reviewed by: _____

Date: _____

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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:		13. Near Vision: Jaeger		14. Color Vision (Test Performed and Results)
R. 20/_____	Corr. to 20/_____	R. 20/_____	Near Vision Corrected R. 20/_____	
L. 20/	Corr. to 20/	L. 20/	L. 20/	

15. Field of Vision (Degrees) R ° L ° 16. Contact Lenses ☐ Yes ☐ 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	Glossophayrngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

43. REFLEXES

DEEP TENDON

	Left					Right				
	0	1	2	3	4	0	1	2	3	4
Triceps										
Biceps										
Patella										
Achilles										

PATHOLOGICAL

	Left		Right	
	Present	Absent	Present	Absent
Babinski				
Hoffman				
Ankle Clonus				

SUPERFICIAL

	Present	Absent	NE
Upper Abdomen			
Lower Abdomen			
Cremasteric			

44. CEREBELLAR FUNCTION

	0	1	2	3	4
Ataxia					
Tremor (intention)					

	Normal	Abnormal
Finger to Nose		
Heel to Shin (Sliding)		
Rapidly Alternating Movements		

45. MUSCLE STRENGTH

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

TONE

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		

	Normal	Abnormal
Sharp		
Soft		

Two Point Discrimination	
Normal	
Abnormal	

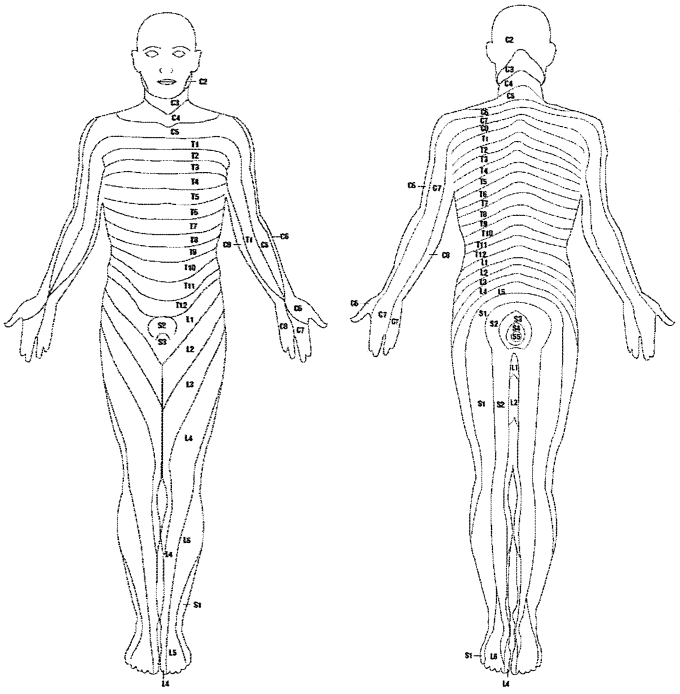
49. ROMBERG

Absent	
Present	

Reviewed by: _____

Date: _____

50. MISCELLANEOUS REMARKS



Date:_____

LABORATORY FINDINGS

51. Urinalysis

Color _____
Appearance _____
Sp. Gravity _____
Ph _____
Microscopic Normal ☐ Abnormal ☐ (See report)

	0	1+	2+	3+	4+
Sugar					
Blood					
Ketones					
Bilirubin					
Protein					

Date:_____

52. Blood Tests

CBC
Normal ☐
Abnormal ☐

Sickle Cell ☐ Pos ☐ Neg

Attach Reports
RPR ☐ Pos ☐ Neg

53. Cardiac Risk Score
No. of Points _____
10 year risk

54. Pulmonary Function

FVC _____
FEV1 _____
FEV1/FVC _____

Date:_____

55. X-ray/MRI

	Normal	Abnormal	(Describe)
Chest	☐	☐	
Lumbar Spine	☐	☐	
Long Bones	☐	☐	
MRI	☐	☐	

Date:_____

56. Electrocardiogram

Static _____
Exercise Stress _____

Date:_____

57. Audiogram

Hz	500	1000	2000	3000	4000	6000	8000
Left							
Right							

Date:_____

58. Comprehensive Metabolic Panel Attach Report

Normal ☐ Abnormal ☐

Lipid Panel (if done)

Normal ☐ Abnormal ☐

Comments: _____

Date:_____

59. Drug Screen

☐ Not collected
☐ Collected, results sent to employer

Work Status:

☐ Fit for diving
☐ Cleared for supervisor
☐ Cleared for topside work only
☐ Cleared with restrictions: _____
☐ Further evaluation needed: _____
☐ Unfit for diving : _____
☐ Unfit

Comments: _____

Examinee Name _____

Physician Signature _____

Physician Name _____

Address **Divers and Drivers Medical Company, PLLC**
PO Box 2529, Poulsbo, WA 98370

Phone Number **360-900-7056/ 360-900-9776**
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Date of Examination _____