

**Laguna Sea Sports & NAUI**  
**Medical History Information Form**

**Medical History Statement:** I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ear and sinus are essential for my safety and well-being. I hereby confirm that to the best of my knowledge my circulatory and respiratory systems and body air spaces are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. *I understand that I may need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness for the rigors of diving.*

Write Y (yes) or N (no) next to each of the following and explain under remarks any yes answers.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Behavioral health problems  | <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Contact Lenses        |
| <input type="checkbox"/> Claustrophobia              | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Dental Plates         |
| <input type="checkbox"/> Agoraphobia                 | <input type="checkbox"/> Respiratory Problems  | <input type="checkbox"/> Physical Disability   |
| <input type="checkbox"/> Migraine Headaches          | <input type="checkbox"/> Back Problems         | <input type="checkbox"/> Serious Injury        |
| <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Back / Spinal surgery | <input type="checkbox"/> Over 40 Years Old     |
| <input type="checkbox"/> Ear or hearing problems     | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Trouble equalizing pressure | <input type="checkbox"/> Ulcers                | <input type="checkbox"/> HIV Positive          |
| <input type="checkbox"/> Sinus trouble               | <input type="checkbox"/> Colostomy             | <input type="checkbox"/> Regular medication    |
| <input type="checkbox"/> Severe hayfever             | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Drug allergies        |
| <input type="checkbox"/> Heart trouble               | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Alcohol or drug abuse |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Recent surgery        | <input type="checkbox"/> Rejected from any     |
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Hospitalized          | activity for medical                           |
| <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Pregnant              | reasons.                                       |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Motion Sickness       |  |

Any medical problem not listed: \_\_\_\_\_

Remarks : \_\_\_\_\_

\_\_\_\_\_

List all medications you are presently taking: \_\_\_\_\_

\_\_\_\_\_

**IF AT ANY TIME DURING YOUR DIVE TRAINING YOUR MEDICAL CONDITION CHANGES NOTIFY  
YOUR INSTRUCTOR IMMEDIATELY**

I certify that the above information is correct to the best of my knowledge (Init.) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Ocean Scuba Sessions

**REAFFIRMATION OF MEDICAL HISTORY INFORMATION**

I certify that the above information is correct to the best of my knowledge (Init.) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_