Name:____ Date:__________________

Please check each question:--->	YES	No	Date of Onset:	Description of issue:
Pulmonary:				
Do you have Chest Congestion?				# times per day: ____ / per wk.____
Have Difficulty breathing OR Shortness of Breath?				# times per day: ____ / per wk.____
Do you have Bronchitis?				
Do you have Asthma?				
Any history of pulmonary problems?				
Pneumothorax?				
Are you a Smoker?				# packs per day:__________
COPD {chronic obstructive pulmonary disease}?				
Ears, Nose, & Sinuses:				
Any history of ear, nose or sinus problems?				circle : EAR NOSE SINUS
*** Details on above question:				
Frequent Ear aches or Infections?				Left: Right:
Do you have Ringing in your ears?				Left: Right:
Do you have Hearing difficulty?				Left: Right:
If Hearing Loss, Cause? {**eg:** age, loud music, accident}				
Trouble flying in an airplane due to pressure?				
Have you had Ear Surgery or Tubes?				Left: Right:
Have you had Myringotomy? {surgical incision into the eardrum, to relieve pressure or drain fluid.}				Left: Right:
Do you have Nasal problems or an obstruction?				
Are you now, or recently getting over Congestion?				
Do you have Frequent Sinus Infections?				
Eyes:				
Any history of eye problems?				
Do you have Cataracts?				Left: Right:
Have you had any eye surgery?				Left: Right:
Have any Retinopathy?				
Do you have watery, itchy or red eyes?				
Do you have Blurred or Tunnel Vision?				
Do you wear Eye Glasses?				
Do you wear Contact lenses?				
Skin :				
Do you have any skin problems?				
Do you have Acne?				
Do you have Hives?				
Do you have hair Loss?				
Digestive Tract:				
Do you frequently OR are you Now Experiencing:				
Nausea, Vomiting or Heartburn?				
Intestinal or Stomach pain?				
Do you have Ulcers?				
Cardiac :				
Any history of cardiac problems?				
Do you have Irregular heartbeat?				
Do you have skipping heartbeat?				
Do you have Rapid or pounding heartbeat?				
Do you get chest pains?				
Do you have a Pacemaker?				
Have you had a Heart Attack?				
Do you have Congestive Heart failure?				
Hypertension				

Name:____ Date:__________________

Please check each question:--->	YES	No	Date of Onset:	Description of issue:
Brain Insult:				
History of Neurological problems?				
Do you have Nervous Disorder?				
Do you have Epilepsy?				# seizures per day: ___ / per wk.___
Have you ever had a Brain Injury?				Details:
Have you ever had a Stroke?				Cause:
Do you have Anoxia? {absence or deficiency of oxygen reaching tissues}				
Ever have Optic Neuritis?				
Have you ever been hit in the head or face?				
Have you ever been knocked unconscious?				
Have you ever had a concussion?				
Have you ever had whiplash or a neck injury?				
Do you have Seizure disorder?				# times per day: ____ / per wk.____
Do you have frequent Headaches?				# times per day: ____ / per wk.____
Do you feel Faintness OR Dizziness often?				# times per day: ____ / per wk.____
Do you have poor short term memory?				
Do you have poor long term memory?				
Do you get confused or have poor comprehension?				
Do you have difficulty making decisions?				
Do you stutter, stammer or slure your speech?				
Do you have any Learning disabilities?				
Diabetes:				
Are you diabetic?				
Are you on Medication/Insulin?				
What is your Blood Sugar?				Range:
Frequency of Sugar monitoring:				Frequency:
Insulin Reaction:				Symptoms:
Do you have any wounds due to diabetes?				location:
ALLERGIES:				
Do you have environmental allergies?				
Are you on allergy medication?				List:
Are you allergic to any medications?				List:
Are you allergic to any foods?				List:
GI/GU: {Gastrointestinal OR Duodenal Ulcers}				
Do you have any history of G.I. or G.U.?				
Do you have Frequent Constipation?				# times per day: ____ / per wk.____
Do you have Frequent diarrhea?				# times per day: ____ / per wk.____
Do you have Frequent Gas?				# times per day: ____ / per wk.____
Do you have No or insufficient control of stool?				cause:
No or insufficient control of urine?				cause:
Do you have frequent or urgent urination?				# times per day: ____ / per wk.____
Do you wear incontinence pads				
Do you have an "Ostomy"?				
Joints / Muscles:				
Do you have Arthritis?				
Do you have Pain or aches in Joints?				# times per day: ____ / per wk.____
Do you have Pain or aches in Muscles?				# times per day: ____ / per wk.____
Do you get middle of the night muscle cramps?				location:____________/#per wk.____
Do you have Stiffnes or limitation of movement?				

Name:____ Date:__________________

Please check each question:--->	YES	No	Date of Onset:	Description of issue:
Energy/Emotions:				
Do you frequently feel Fatigue or sluggish?				
Do you lack interest or enthusiasm?				
Do you often feel Hyperactive or Restlessness?				
Do you frequently have mood swings?				# times per day: ____ / per wk.____
Do you frequently feel fear or nervousness?				# times per day: ____ / per wk.____
Do you frequently feel anger or aggressiveness?				# times per day: ____ / per wk.____
Do you have trouble sleeping through the night?				# of times you wake up a night:_____
Do you sleep to much,have trouble staying awake?				# of hours you sleep per night:______
Do you have feelings of depression?				how often:_____ last how long:______
Have you had Rapid Weight Change?				Weight Loss:____ Weight Gain:____
Prosthetics:				
Do you wear any prosthetic device?				Type:
Do you wear Dentures?				Upper:__Lower:__Partial:__Bridge:__
Do you wear Hearing Aides?				Left: Right:
Do you have breast implants?				Filler:________ Left: ____ Right:___
Additional:				
Do you have Cancer?				
Do you have frequent illness?				
Are you pregnant?				how far along are you? ____________
Are you claustrophobic?				
How do you learn best?				Reading____ Visual_____Verbal____
Are you on a nutritional program?				What:
Do you have doctor's written diagnoses, X-Ray, MRI, Brain Scan or ANY form of record for what you are diving for today? (this will be a helpful way for us to compare your PRE and POST diving, once perscription has been completed.)				Pre diving records:

Anything you feel would be beneficial for us to know, that has not already been asked?

If so, please give details here: