



NASE WORLDWIDE

MEDICAL HISTORY FORM



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

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

☐	☐	For Females ONLY	☐	☐	Painful Menses	Last Menstrual Period _____
☐	☐	Irregular Menses	☐	☐	Pregnancy	

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES _____

13. LIST ALL SURGERIES

YEAR

14. LIST ALL HOSPITALIZATIONS

YEAR

15. LIST ALL INJURIES

YEAR

16. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

17 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:

18. **My Personal Physician is:** Name _____
 Address _____
 City, State _____
 Phone Number _____



19. **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
 Maximum Depth _____
 Maximum Duration (Days) _____
 Heliox Yes ☐ No ☐
 Trimix Yes ☐ No ☐
 Nitrox Yes ☐ No ☐

20. **DIVING EXPERIENCE (Number of years experience):**

Have you passed an oxygen tolerance test?
 Air _____ Yes ☐ No ☐
 Mixed Gases _____
 Saturation _____ Name of Diving School _____

21. **INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS**
If None put 0 (Zero) List any residuals

Bends, pain only _____
 Bends, neurological _____
 Chokes _____
 Inner ear _____

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

	Yes	No	Details
Gas Embolism	☐	☐	_____
Oxygen Toxicity	☐	☐	_____
CO ₂ Toxicity	☐	☐	_____
CO Toxicity	☐	☐	_____
Ear/Sinus Squeeze	☐	☐	_____
Ear Drum Rupture	☐	☐	_____
Deafness	☐	☐	_____

	Yes	No	Details
Lung Squeeze	☐	☐	_____
Near Drowning	☐	☐	_____
Asphyxiation	☐	☐	_____
Vertigo (Dizziness)	☐	☐	_____
Pneumothorax	☐	☐	_____
Nitrogen Narcosis	☐	☐	_____
Loss of Consciousness	☐	☐	_____

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

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 _____

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

Yes	No	Give Date
☐	☐	Chest X-Ray _____
☐	☐	Longbone Series _____
☐	☐	Back (Spine) X-Ray _____
☐	☐	ENG _____
☐	☐	EEG _____
☐	☐	EMG _____

Yes	No	Give Date
☐	☐	Nerve Condition Studies _____
☐	☐	Pulmonary Function Studies _____
☐	☐	Audiogram _____
☐	☐	EKG _____
☐	☐	Exercise (Stress) EKG _____
☐	☐	MRI _____

25. **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 _____



NASE WORLDWIDE

PHYSICAL EXAMINATION FORM



Employer		Date		Date of Birth		Age	
1. Last Name		First Name		Middle Name		2. 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		Near Vision Corrected		14. Color Vision (Test Performed and Results)	
R. 20/ _____		R. 20/ _____		R. 20/ _____			
L. 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					
		42. Pelvic Exam					

NEUROLOGICAL EXAMINATION

43. 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			

44. REFLEXES

DEEP TENDON

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

Babinski
Hoffman
Ankle Clonus

PATHOLOGICAL

	Left	Right
	Present Absent	Present Absent

SUPERFICIAL

	Present	Absent	NE
Upper Abdomen			
Lower Abdomen			
Cremasteric			

45. CEREBELLAR FUNCTION

	0 1 2 3 4
Ataxia	
Tremor (intention)	
	Normal Abnormal
Finger to Nose	
Heel to Shin (Sliding)	

46. MUSCLE

Right Upper Extremity
Left Upper Extremity
Right Lower Extremity
Left Lower Extremity

STRENGTH

1 2 3 4 5

TONE

Normal Abnormal

47. PROPIOCEPTION

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

48. NYSTAGMUS

	Present	Absent
End Point Lateral Gaze		
Pathological		

49. SENSATION

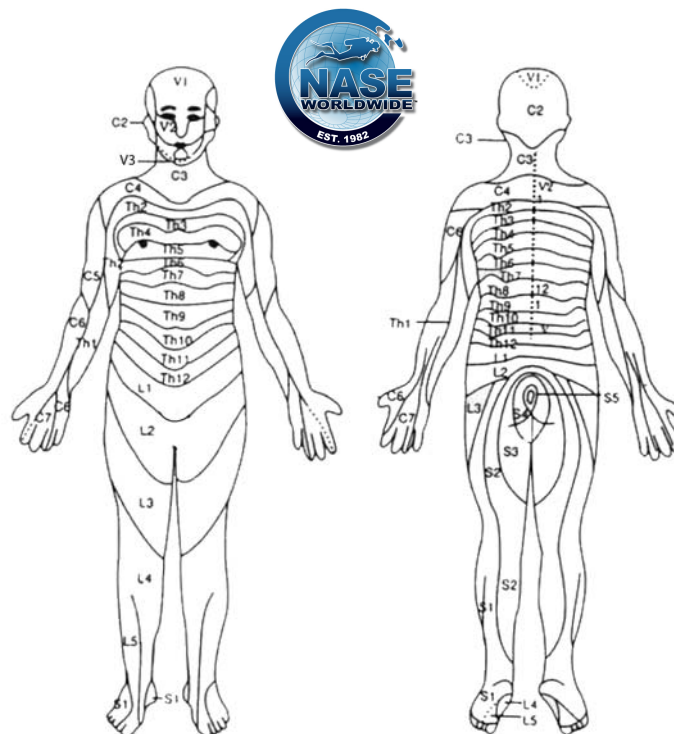
	Normal	Abnormal
Hot		
Cold		

	Normal	Abnormal
Sharp		
Soft		

50. RHOMBERG

Two Point Discrimination
Normal
Abnormal

Absent
Present

[illegible]

52.	Urinalysis		Color	_____	Sugar	<table border="1"> <tr> <th>0</th> <th>1+</th> <th>2+</th> <th>3+</th> <th>4+</th> </tr> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>					0	1+	2+	3+	4+																					53. Blood Tests	CBC		Attach Reports	
	0	1+	2+	3+	4+																																			
Appearance	_____	Blood					RPR	☐ Pos																																
Sp. Gravity	_____	Ketones						☐ Neg																																
Ph	_____	Bilirubin						HIV	☐ Pos																															
		Protein						☐ Neg																																
54. Pulmonary Function		55. X-rays		Normal	Abnormal	(Describe)																																		
FVC		Chest		☐	☐	_____																																		
FEV1		Lumbar Spine		☐	☐	_____																																		
FEV1/FVC		Long Bone Series		☐	☐	_____																																		
		Other		☐	☐	_____																																		
56. Electrocardiogram	Static		57. Audiogram																																					
	Exercise Stress		<table border="1"> <tr> <th>Hz</th> <th>500</th> <th>1000</th> <th>2000</th> <th>3000</th> <th>4000</th> <th>6000</th> <th>8000</th> </tr> <tr> <td>Left</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Right</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>								Hz	500	1000	2000	3000	4000	6000	8000	Left								Right													
	Hz	500	1000	2000	3000	4000	6000	8000																																
Left																																								
Right																																								
58. Comprehensive Metabolic Panel		Attach Report	59. Drug Screen																																					
Lipid Panel (if done)		Comments:																																						
Normal ☐		Normal ☐																																						
Abnormal ☐		Abnormal ☐																																						
			☐ Not collected ☐ Collected, results sent to employer																																					

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

Phone Number