

YSCUBA YMCA National SCUBA Program

MEDICAL FORM

Patient's Name: _____ Date: _____
 Birthdate: _____ Age: _____ Sex: _____
 History - Chief Complaint and/or Purpose of Examination: _____

Pertinent Past Medical History: _____

Pertinent Family History: _____

Alcohol History: _____ Smoking History: _____

Allergies: _____

Medications: _____

Physical Conditioning: _____

Review of Systems (if applicable): _____

Physical Exam: BP _____ Pulse _____ Resp _____ Temp _____ Ht _____ Wt _____

Findings:

	Normal	Abnormal	Comments
			General Appearance
			Mental Status
			HEENT
			Neck
			Chest
			Heart
			Vascularity
			Abdomen
			Extremities
			Joints
			Neurological

Additional Findings and/or Comments: _____

Significant Lab Tests and Studies (if indicated):

CBC _____ Chest X-Ray _____ EKG _____
 Urinalysis _____ Sinus Films _____ Stress Test (EKG) _____
 Liver Studies _____ Bone & Joint Survey _____ Pul Function _____
 Diabetic Evaluation _____ Brain Scan _____ Hearing Test _____ Gross _____ Audiogram
 EEG _____

Other Tests and/or Comments: _____

Impressions: _____

Conclusion:

_____ Approval for SCUBA Diving
 _____ Disapproval for SCUBA Diving

Signature: _____ MD/DO
 Doctor's Name (print) _____
 Address: _____
 City _____ State _____ Zip _____