NOAA 56-59
(5-07)

NOAA DIVING - ANNUAL MEDICAL HISTORY REPORT

ALL NOAA-certified divers must complete and submit this form each year to the NOAA Diving Center by MARCH 1st. Failure to submit this form may result in NOAA diving certification suspension. Forms may be faxed to the Diving Center at (206) 526-6506, or mailed to NDC, 7600 Sand Point Way NE, Seattle, WA 98115.

1. NAME (Last, First M.I.)	2. WORK PHONE	3. Email ADDRESS

4. WORK ADDRESS	5. AGENCY
	6. DIVING UNIT

7. DATE OF BIRTH	8. AGE	9. SEX	10. STATEMENT OF PRESENT HEALTH
		____ MALE ____ FEMALE	

11. CURRENT MEDICATION & DOSAGE *(Note if new medication or if dosage has changed)*	12. ALLERGIES (List All)

13. PAST/CURRENT MEDICAL HISTORY *(Do you have or have you ever had the following)*

INSTRUCTIONS: Check "Yes" and explain any item listed below that has **changed** in the last year or since you last submitted a Medical History Form to the NOAA Diving Center. A physician's signature is not required for this form.

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Trouble with your ears, including ruptured ear drum, difficulty clearing your ears, or surgery			Heart disease or high cholesterol			Surgery of any kind (if yes, explain below)		
			Diabetes mellitus			Hospitalization for any reason (if yes, explain below)		
Decompression sickness, embolism, or other diving malady			Anatomical heart abnormalities including patent foramen ovale, valve problems, etc					
						Take any medications (list above)		
Depression, anxiety, claustrophobia, or any other psychiatric disorder			Heart rhythm problems			Allergic to any medications, foods, or environmental factors (list above)		
			Need for a pacemaker					
Eye surgery			Difficulty with exercise			Smoke (if yes, how much)		
Loss of consciousness for any cause			High blood pressure			Drink alcoholic beverages (how much)		
Epilepsy, or other seizures, convulsions, or fits			Collapsed lung			Family history of high cholesterol		
Stroke or any neurological deficit			Asthma			Family history of heart disease or stroke		
Recurring neurologic disorders, including transient ischemic attacks			Exposed to a person with tuberculosis (TB), or have persistent cough, sweats, or weight loss			Family history of diabetes		
						Family history of asthma		
Aneurysms or bleeding in the brain			Tuberculosis or positive TB test			Substance abuse, including alcohol		
Trouble with dizziness			Other lung diseases			Use any illegal substances		
Head injury			Pregnancy			Thyroid trouble		
Disorders of the blood or easy bleeding			Date of last menstrual period:			Bone, joint, or other deformity		

14. EXPLAIN IN DETAIL "YES" ANSWERS TO ANY OF THE ABOVE QUESTIONS

I certify that the above answers and information represent a true, accurate, and complete description of my medical history.

15. TYPED OR PRINTED NAME OF DIVER	16. SIGNATURE	17. DATE