

# **14<sup>th</sup> International Submarine Races - Participant Medical History - Form 5.4**

## **To the Participant:**

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in this event.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in this event.

- |   |  |
|---|--|
| <input type="checkbox"/> Are you pregnant or do you suspect you may be pregnant?  | <input type="checkbox"/> History of chest surgery?   |
| <input type="checkbox"/> Do you regularly take prescription or nonprescription medications? (with the exception of birth control)   | <input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)?                  |
| <input type="checkbox"/> Are you over 45 years of age <i>and</i> have one or more of the following? <ul style="list-style-type: none"><li>• currently smoke a pipe, cigars, or cigarettes</li><li>• have a high cholesterol level</li><li>• have a family history of heart attacks or strokes</li></ul> | <input type="checkbox"/> Behavioral health problems?   |
| <input type="checkbox"/> History of diving accidents or decompression sickness?   | <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them?            |
| <input type="checkbox"/> History of diabetes?   | <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them?               |
| <input type="checkbox"/> Inability to perform moderate exercise (walk one mile within 12 minutes)?  | <input type="checkbox"/> History of blackouts or fainting (full/partial loss of consciousness)?          |
| <input type="checkbox"/> History of any heart disease?  | <input type="checkbox"/> Do you frequently suffer from motion sickness (seasick, carsick, etc.)?         |
| <input type="checkbox"/> Angina or heart blood vessel surgery?  | <input type="checkbox"/> History of recurrent back problems?   |
| <input type="checkbox"/> History of ear disease, hearing loss or problems with balance?   | <input type="checkbox"/> History of back surgery?  |
| <input type="checkbox"/> History of bleeding or blood disorders?  | <input type="checkbox"/> History of back, arm or leg problems following surgery, injury or fracture?     |
| <input type="checkbox"/> History of ulcers or ulcer surgery?  | <input type="checkbox"/> History of high blood pressure or take medications to control blood pressure?   |
| <input type="checkbox"/> History of drug or alcohol abuse?  | <input type="checkbox"/> History of heart attacks?   |
|   | <input type="checkbox"/> History of ear or sinus surgery?  |
|   | <input type="checkbox"/> History of problems equalizing (popping) ears with airplane or mountain travel? |
|   | <input type="checkbox"/> History of any type of hernia?  |
|   | <input type="checkbox"/> History of colostomy?   |

## **HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE...**

- |   |   |
|---|---|
| <input type="checkbox"/> Asthma or wheezing with breathing or wheezing with exercise? | <input type="checkbox"/> Frequent or severe attacks of hayfever or allergy? |
| <input type="checkbox"/> Frequent colds, sinusitis, or bronchitis?                    | <input type="checkbox"/> Any form of lung disease?                          |
| <input type="checkbox"/> Pneumothorax (collapsed lung)?                               |   |

## **I HAVE READ THIS AGREEMENT, I UNDERSTAND IT, I AGREE TO BE BOUND BY IT.**

\_\_\_\_\_  
Signature of Participant

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (Print)

\_\_\_\_\_  
Witness Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone Number

**SIGNATURE OF PARENT(S) OR GUARDIAN(S) IF PARTICIPANT IS A MINOR**, and by their signature they, on my behalf release all claims that both they and I may have.

\_\_\_\_\_  
(Parent signature if Participant is a minor)

Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent signature if Participant is a Minor)

Date: \_\_\_\_\_

**EVENT REPRESENTATIVE CONFIRMATION: I HAVE REVIEWED THIS AGREEMENT AND CONFIRM THAT IT HAS BEEN PROPERLY COMPLETED.**

Signature of Event Representative: \_\_\_\_\_ Date \_\_\_\_\_