Medical History Form – Participant Record

Marine activities (snorkeling/canoeing), you must be responsible for your own actions. Instructors and Doctors will not be held liable for accidents caused by unhealthy. Therefore, we need to understand the physical health of the participants before the event begins.

This Medical History Form was developed to prevent accidents caused by health discomfort. In particular, in order to let the guides (instructors) of the next event know the status of the participants, the participants are required to fill out the medical records.

Please circle "Yes" or "No" for the following questions. If you are not sure, or if you don't know the situation, please circle "Yes". Circled "Yes" indicates that there may be a disease or related medical history that may affect safety. After filling out, please hand it to the guide (instructor).

◆Participant entry column

Name _____ Phone _____

Birthday _____ Year _____ m _____ d Age _____

Address 〒 _____

Ⅰ Are there the following symptoms now or in the past？

Yes ・ No	Do you often have a migraine (pulsating headache)？ Or are you taking preventive medicine for this？
Yes ・ No	Have you ever had a neurological disease(The body can't move, the body is numb, hard to talk, or suddenly it's dark in front of you)？
Yes ・ No	In the past five years, have you lost consciousness because you hit your head？
Yes ・ No	Have you ever had epileptic seizures or seizures？
Yes ・ No	Do you have severe dizziness (car sickness, sea sickness.)？
Yes ・ No	Do you have high blood pressure? Or are you taking medications that lower your blood pressure？
Yes ・ No	Have you ever had angina or myocardial infarction? Or have you ever had a heart or blood vessel operation？
Yes ・ No	Do you have any symptoms or diseases such as arrhythmia, chest pain, shortness of breath during exercise？
Yes ・ No	Do you have other heart diseases？
Yes ・ No	Do you have asthma？ Or have an abnormal sound when breathing？
Yes ・ No	Have you ever had a pneumothorax？
Yes ・ No	Do you have other lung diseases？ Or easy to have to cough up phlegm？
Yes ・ No	Have you ever had a chest disease(except lung disease)？ or have had a chest operation？
Yes ・ No	Do you often have dehydration or diarrhea, vomiting or nausea？
Yes ・ No	Is there any ulcer in your stomach or intestine？ Or have you ever had ulcer operation？
Yes ・ No	Have you ever had a bowel operation (including artificial anal operation)？
Yes ・ No	Is your neck, back or limbs damaged？ Or treated because of abnormalities？
Yes ・ No	Have you had a fracture, sprain or dislocation, and there are sequelae (pain, joint instability)？
Yes ・ No	Do you have blood disease (anemia, easy bleeding, blood clots) or vascular disease (blood blockage or poor blood circulation)？ Or have you ever had a related operation？
Yes ・ No	Do you have endocrine diseases (diabetes or high blood sugar, thyroid disease)？
Yes ・ No	Have you been told that you have a mental illness, anxiety (including panic attacks, fear of heights, neurosis) or behavioral disorders (emotional instability, hyperactivity, inability to act in groups)？
Yes ・ No	Have you ever had symptoms of allergic rhinitis (including severe hay fever)？
Yes ・ No	Are you susceptible to sinusitis (accumin) and bronchitis (acute, chronic, allergic)？
Yes ・ No	Have you ever had a sinus operation？
Yes ・ No	Have you ever had an ear disease (external otitis media, otitis media, tympanic membrane perforation), hearing abnormalities (such as hearing loss or tinnitus) or abnormal balance (dizziness)? Or had related operation？
Yes ・ No	Do you have any other abnormalities in your ears (such as earaches due to pressure changes)？
Yes ・ No	Do you have hernia (intervertebral disc, groin)？ Or had related operation？
Yes ・ No	Have you ever had a diving disorder (trauma due to changes in ear, sinus or lung pressure, decompression sickness or arterial gas embolism)？
Yes ・ No	Have you had drugs, alcohol addiction, or used narcotics in the past five years？

Ⅱ Are you taking prescription now？ Yes ・ No

「Yes」 …(Disease name Prescription name Taking frequency /day)

Ⅲ Have you received any medical care in these 3 months？ Yes ・ No

「Yes」 …(content)

Ⅳ Questions about health checks at schools, companies and communities.

Yes ・ No Have you had a physical examination this year?？

Yes ・ No Are there any items that doctors recommend for precision inspection but have not checked yet？

Ⅴ Questions for women.

Yes ・ No Is there any possibility of pregnancy？

Yes ・ No Are you more likely to feel unwell before or during your menstruation？

Ⅵ Questions for older than 45 years old.

Yes ・ No Do you smoke？

Yes ・ No Is your cholesterol too high？

Ⅶ Do you have any doubts about your physical condition？ Yes ・ No

「Yes」 …(content)

According to what I know, the medical records mentioned above are correct.
This medical record is intended to assess the current physical condition, not to predict future physical conditions.
In addition, I agree to assume all responsibility for accidents caused by unclear health conditions or for explanations or explanations by the tour guide (instructor) based on questions raised by the medical record.

Participant signature Date Y M D

(Participants are underage)

Guardian signature Date Y M D

◆Physicians entry column

Those who hold this medical record are those who want to participate in recreational activities at sea (snorkeling/canoeing). Based on the above, the tour guide (instructor) advises the participants to go to the hospital for examination. When checking, please pay special attention to the item marked "Yes" above.
The purpose of the examination is to look at the opinions provided by participants when conducting marine activities(snorkeling/canoeing) from a medical point of view.
Please tick the "Impressions from a medical perspective" section below and add your findings or comments as necessary.

Impressions from a medical perspective

☐ There are no diseases or problems that are not suitable for maritime activities (snorkeling/canoeing).

☐ Marine activities (snorkeling/canoeing) are not recommended.

Findings / comments

Hospital name Date Y M D

Hospital address 〒

Doctor's name Phone