



# PROJECT DIVE EXPLORATION

## Participant Enrollment (Diver Data)

FRC Code

| Personal Identification                                      |                            |  |               |
|--|----------------------------|--|---------------|
| FIRST NAME   | M.I.                       | LAST/FAMILY NAME   |               |
| SEX<br><input type="checkbox"/> M <input type="checkbox"/> F | DATE OF BIRTH (mm/dd/yyyy) | DAN MEMBER<br><input type="checkbox"/> Yes <input type="checkbox"/> No | MEMBER NUMBER |
| Contact Information  |                            |  |               |
| WORK TELEPHONE   | HOME TELEPHONE             | E-MAIL ADDRESS   |               |
| STREET ADDRESS   |                            |  |               |
| CITY   | STATE                      | ZIP/POSTAL CODE  | COUNTRY       |

| Medical History   |  |  |
|---|--|--|
| CIGARETTE/TOBACCO SMOKING<br><input type="checkbox"/> Yes <input type="checkbox"/> No | HEIGHT<br>_____ <input type="checkbox"/> ft/in <input type="checkbox"/> cm | WEIGHT<br>_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg |

| Please read entire list and check any and all conditions or medications that apply to you. |   |                 |
|--|---|-----------------|
| Medical Conditions   | Current Medications   | Medication Name |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Allergy                                |                 |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Antibiotics                            |                 |
| <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Anti-depressants                       |                 |
| <input type="checkbox"/> Back Surgery  | <input type="checkbox"/> Anti-epileptics                        |                 |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Anti-Malaria                           |                 |
| <input type="checkbox"/> Ear/Sinus Surgery   | <input type="checkbox"/> Asthma (Inhaler)                       |                 |
| <input type="checkbox"/> Ear/Sinus Problems  | <input type="checkbox"/> Asthma (Oral Drug)                     |                 |
| <input type="checkbox"/> Flu or Cold   | <input type="checkbox"/> Birth Control                          |                 |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Blood Pressure                         |                 |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Decongestant                           |                 |
| <input type="checkbox"/> Joint/Muscle Pain   | <input type="checkbox"/> Diarrhea                               |                 |
| <input type="checkbox"/> Nervous System Disorder   | <input type="checkbox"/> Flu or Cold                            |                 |
| <input type="checkbox"/> Previous Treatment for DCI  | <input type="checkbox"/> Heart & Circulation                    |                 |
| <input type="checkbox"/> Pregnant (currently)  | <input type="checkbox"/> Insulin                                |                 |
| <input type="checkbox"/> Peripheral vascular disease                                       | <input type="checkbox"/> Oral Diabetics                         |                 |
| <input type="checkbox"/> Pulmonary   | <input type="checkbox"/> Pain Relief                            |                 |
| <input type="checkbox"/> Surgery of any kind   | <input type="checkbox"/> Seasickness                            |                 |
| <input type="checkbox"/> Seasickness   | <input type="checkbox"/> Vitamins/Dietary Supplements           |                 |
| <input type="checkbox"/> Other (Describe on next page)                                     | <input type="checkbox"/> Other:                                 |                 |
| <input type="checkbox"/> Nothing Significant   | <input type="checkbox"/> I am not taking <b>ANY</b> medications |                 |

| Diving Experience                         |   |
|---|---|
| YEAR OF FIRST CERTIFICATION:<br><br>_____ | HIGHEST LEVEL OF CERTIFICATION (Pick only one – highest level)<br><input type="checkbox"/> Student <input type="checkbox"/> Open Water ☆ <input type="checkbox"/> Advanced/Specialty (AOW) ☆☆ <input type="checkbox"/> Rescue Diver<br><input type="checkbox"/> Dive Master ☆☆☆ <input type="checkbox"/> Instructor ☆☆☆☆ <input type="checkbox"/> Technical: cave/cavern/deep diving<br><input type="checkbox"/> Scientific <input type="checkbox"/> Commercial <input type="checkbox"/> Military |

Estimate how many dives have you made in the past: 5 years: \_\_\_\_\_ 12 months: \_\_\_\_\_

When was your last dive before volunteering for PDE? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

If that dive was less than 48 hours before volunteering, please specify the end time: \_\_\_\_:\_\_\_\_ (hh:mm)

**ADDITIONAL COMMENTS:** Please describe health problems or significant details about your medical history on the back of this form.



**ADDITIONAL COMMENTS** May be entered in narrative in Daily Report

Please describe any significant details about your medical history that would be of interest to DAN.

Thank you for deciding to participate in DAN's Project Dive Exploration. You are taking a big step to help shape the future of dive safety. **Please fill out all forms accurately and completely. All information collected here will only be used for research purposes and will be kept strictly confidential.** If necessary, a staff member of the Divers Alert Network may need to contact you for further clarification of this personal information. Only the study staff will have access to the information. Your name will not appear when the results are reported in medical journals or at meetings. In addition, your records may be reviewed in order to meet federal or state regulations. Reviewers may include, for example, representatives from the Duke University Health System (DUHS) Institutional Review Board. The study results will be retained in your research record for at least six years or until after the study is completed, whichever is longer. At that time, either the research information not already in your record will be destroyed or information identifying you will be removed from such study results at DUHS. Any research information in your medical record will be kept indefinitely.

I have received information explaining my participation in Project Dive Exploration. Initials \_\_\_\_\_