AS/NZS 2299.1 Occupational Diving Medical Examination - Medical Questionnaire

Applicant Details

Full name:	DOB:
Address:	
Occupation:	Sex: Male
Date of last dive medical:	Contact number:

How often do you participate in physical activity?

☐ Rarely ☐ < once/week ☐ Weekly ☐ 2-3 times/week ☐ Most days

Type of physical activity:

Current smoker? ☐ Yes ☐ No Previous smoker? ☐ Yes ☐ No Number of cigarettes/day:

Do you drink alcohol? ☐ Yes ☐ No Number of drinks/week:

In the past 12 months, have you consumed or smoked any illicit drugs? ☐ Yes ☐ No
Details:

Do you take any tablets, medicines or drugs? ☐ Yes ☐ No
Details:

Do you have any allergies? ☐ Yes ☐ No
Details:

Have you ever had any reactions to drugs, medicines or foods? ☐ Yes ☐ No
Details:

Applicant's General Practitioner

Doctor name:
Clinic name:
Address:
Contact number:

Next of Kin / Emergency Contact

Name:	
Address:	
Relationship:	Contact number:

Type of Medical

☐ Unrestricted - including saturation
☐ Unrestricted - not including saturation
☐ Limited Occupational Diving - specify type:
☐ Recreational Diving Industry work only

Diving History

Approx. date of first compressed air dive:		Total hours under pressure:
Types of diving experience: ☐ Scuba air ☐ Surface supply ☐ Saturation ☐ Scuba mix gas ☐ Surface deco ☐ Oxygen ☐ Hookah ☐ Bell diving		
Number of dives to date:	Longest dive: hrs mins	Deepest dive: m

Have you ever suffered from:

• ear squeeze?	☐ Yes	☐ No
• sinus squeeze?	☐ Yes	☐ No
• decompression illness?	☐ Yes	☐ No
• headaches during or after diving?	☐ Yes	☐ No
• extreme tiredness after diving?	☐ Yes	☐ No
Any other diving-related problem?	☐ Yes	☐ No

If yes, please specify:

Have you ever had, or do you now have or suffer from, any of the following?

			Comments:
Prescription spectacles	☐ Yes	☐ No	
Contact lenses	☐ Yes	☐ No	
Eye or vision problem	☐ Yes	☐ No	
Dentures or plate	☐ Yes	☐ No	
Recent dental procedure	☐ Yes	☐ No	
Hay Fever	☐ Yes	☐ No	
Sinusitis	☐ Yes	☐ No	
Nosebleeds	☐ Yes	☐ No	
Deafness or ringing noises in the ear	☐ Yes	☐ No	
Ear infections or discharge from the ear	☐ Yes	☐ No	
Giddiness or loss of balance	☐ Yes	☐ No	
Operation on the ear	☐ Yes	☐ No	
Other ear, nose or throat problem	☐ Yes	☐ No	
Severe motion sickness	☐ Yes	☐ No	
Need to take seasickness medication	☐ Yes	☐ No	
Problems with ears or sinuses when flying in aircraft	☐ Yes	☐ No	
Severe or frequent headaches	☐ Yes	☐ No	
Migraine	☐ Yes	☐ No	
Fainting or blackouts	☐ Yes	☐ No	
Convulsions, fits or epilepsy	☐ Yes	☐ No	
Unconsciousness	☐ Yes	☐ No	
Sleepwalking	☐ Yes	☐ No	
Severe depression	☐ Yes	☐ No	

Have you ever had, or do you now have or suffer from, any of the following?

Claustrophobia	☐ Yes	☐ No	Comments:
Mental illness	☐ Yes	☐ No	
Heart disease	☐ Yes	☐ No	
Abnormal blood test	☐ Yes	☐ No	
ECG	☐ Yes	☐ No	
Palpitations or consciousness of your heartbeat	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Rheumatic fever	☐ Yes	☐ No	
Pain or discomfort in the chest on exertion	☐ Yes	☐ No	
Shortness of breath on exertion	☐ Yes	☐ No	
Bronchitis or pneumonia	☐ Yes	☐ No	
Pleurisy or severe chest pain	☐ Yes	☐ No	
Coughing up blood or phlegm	☐ Yes	☐ No	
Chronic or persistent cough	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Pneumothorax	☐ Yes	☐ No	
Frequent chest colds or flu	☐ Yes	☐ No	
Asthma or wheezing	☐ Yes	☐ No	
Need to use a puffer or inhaler	☐ Yes	☐ No	
Operation on chest, lungs or heart	☐ Yes	☐ No	
Other chest complaint	☐ Yes	☐ No	
Indigestion, acid reflux or peptic ulcer	☐ Yes	☐ No	
Vomiting blood or passing red or black bowel motions	☐ Yes	☐ No	
Recurrent vomiting or diarrhoea	☐ Yes	☐ No	
Jaundice, hepatitis or liver disease	☐ Yes	☐ No	
Malaria or other tropical diseases	☐ Yes	☐ No	
Severe loss of weight	☐ Yes	☐ No	
Hernia rupture	☐ Yes	☐ No	
Back injury	☐ Yes	☐ No	
Significant joint problem or sports injury	☐ Yes	☐ No	
Limitation of movement	☐ Yes	☐ No	
Fracture	☐ Yes	☐ No	
Paralysis or muscle weakness	☐ Yes	☐ No	
Kidney or bladder disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Sickle cell disease	☐ Yes	☐ No	
Bleeding problem or other blood disease	☐ Yes	☐ No	
Skin disease	☐ Yes	☐ No	
Contagious disease	☐ Yes	☐ No	
Head Injury or concussion	☐ Yes	☐ No	

Surgical History

Previous operations or surgery	☐ Yes	☐ No	Comments:
If yes, please specify:			

Other medical history:

Have you been admitted to hospital?	☐ Yes	☐ No	Comments:
Have you been rejected for life insurance?	☐ Yes	☐ No	
Have you failed a medical examination?	☐ Yes	☐ No	
Have you been unable to work on medical grounds?	☐ Yes	☐ No	
Do you have any other illness or health problems?	☐ Yes	☐ No	
If yes, please specify:			

Family History

Is there any family history of heart disease?	☐ Yes	☐ No	Comments:
Is there any family history of sudden death?	☐ Yes	☐ No	
Is there any family history of high cholesterol?	☐ Yes	☐ No	
Is there any family history of diabetes?	☐ Yes	☐ No	
Is there any family history of asthma or chest disease?	☐ Yes	☐ No	
Are you aware of any inherited diseases that run in your family? If yes, please specify:	☐ Yes	☐ No	

Females only

Are you now pregnant or planning to be?	☐ Yes	☐ No	Comments:
Do you have periods which incapacitate you or may reduce your physical/mental performance?	☐ Yes	☐ No	

Candidate Statement

I certify that the above information is true and complete to the best of my knowledge. I hereby authorise the dive doctor to obtain or supply medical information regarding me to other doctors as may be necessary for medical purposes in my personal interest.

Signed: Date: