Recreational Diving Medical Examination - Medical Questionnaire

Adapted from the SPUMS diving medical 2020

HEALTH STATEMENT FOR PERSONS WISHING TO UNDERTAKE SCUBA-DIVING TRAINING

The provision of inaccurate, incomplete or misleading information, or withholding any information is likely to place you at risk and renders any subsequent medical opinion unreliable.

Introduction

This is a medical questionnaire designed to identify any health issues that may increase the risk to you from undertaking SCUBA diving.

In order to undertake dive training, you will be required to sign the form on the understanding that relevant medical details may be passed onto your dive trainer.

You will also be informed of some potential risks involved in scuba diving and of the conduct required of you during the SCUBA training programme. Your signature on this statement is required for you to participate in the SCUBA training program offered.

If you are under 18 years of age, you must have this questionnaire signed by a parent or guardian.

Training to be offered by (instructors) and

located at (facility)

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. To SCUBA dive safely, you should not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your lungs, heart and circulation must be in good health. All body air spaces such as the sinuses and middle ears must be normal and healthy. A person with heart disease, a current head cold or lung congestion, epilepsy (fits), any severe medical problem or who is under the influence of alcohol or drugs should not dive. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should inform the doctor and the instructor before participating in this programme.

You will also learn from the instructor the important safety rules regarding breathing and ear clearing while SCUBA diving. Improper use of SCUBA equipment can result in serious injury. You must be thoroughly instructed in its use under direct supervision of a qualified instructor to use it safely.

If you have any additional questions regarding this Medical Statement of the Medical Questionnaire section, review them with your instructor before signing.

Candidate initials _______

Applicant Details

Full name:	DOB:
Address:	
Occupation:	Sex:
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:

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

Condition	Yes	No	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	
Claustrophobia	☐ Yes	☐ No	
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	

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

Other chest complaint	☐ Yes	☐ No	Comments:
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?	☐ Yes	☐ No	
If yes, please specify:			

Females only

Question	Yes	No	Comments:
Are you now pregnant or planning to be?	☐ Yes	☐ No	

Water skills and diving history

Question	Yes	No	Comments:
Do you have any previous diving experience?	☐ Yes	☐ No	
Please detail when and how many dives performed:			
Previous qualifications (if any):			
Can you swim?	☐ Yes	☐ No	
Any previous problems during/after swimming/diving?	☐ Yes	☐ No	
If yes, please specify:			
Have you ever had decompression illness?	☐ Yes	☐ No	
If yes, please specify:			
Do you snorkel regularly?	☐ 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:

Note

Any chronic disease, such as hepatitis A, B, C, HIV or tuberculosis, may increase your risks from diving. If you have a chronic disease, please discuss it with the doctor who will then be able to advise you whether you will be at increased risk.