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AS/NZS 2299.1 Occupational Diving Medical Examination—Medical Questionnaire

Please complete the following:

Surname Given names

Address

Date of birth Sex M F

Phone (home) Phone (work) Phone (mobile)

Occupation

Most recent dive medical date

Name of Diver's General Practitioner

Type of Medical

Unrestricted—including saturation Limited Occupational Diving—specify type.......................

Unrestricted—not including saturation Recreational Diving Industry work only

Do you participate in any regular physical activity: Rarely <1/week Weekly 2–3/week Most days
Type of physical activity:

How many cigarettes do you smoke per day? Have you been a smoker in the past? Yes No

Do you drink alcohol? Yes No How many drinks per week (average)?

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

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

Do you have any allergies? Yes No
List:

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

Next of kin name Relationship

Address

Phone number(s)

Diving history to date

Doctor's use only

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

How many dives to date..

Longest dive ....

Deepest dive..

Have you ever suffered from—

ear squeeze? .... ☐ Yes ☐ No

sinus squeeze? .... ☐ Yes ☐ No

decompression illness? .... ☐ Yes ☐ No

headaches during or after dive? .... ☐ Yes ☐ No

extreme tiredness after dive? .... ☐ Yes ☐ No

Any other diving-related problems? .... ☐ Yes ☐ No

If yes, specify ....

Candidate's name ....

Have you ever had, or do you now have or suffer from, any of the following?		Doctor's use only
Prescription spectacles	☐ Yes ☐ No	
Contact lenses	☐ Yes ☐ No	
Eye or visual 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	
Head injury or concussion	☐ 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	
TB	☐ 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 disease	☐ Yes ☐ No	
Severe loss of weight	☐ Yes ☐ No	

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		Doctor's use only
Hernia or rupture	☐ Yes ☐ No	

Candidate's name ....

		Doctor's use only
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	
Have you ever had, or do you now have or suffer from, any of the following?		
Sickle cell disease	☐ Yes ☐ No	
Bleeding problem or other blood disease	☐ Yes ☐ No	
Skin disease	☐ Yes ☐ No	
Contagious disease	☐ Yes ☐ No	
Operations	☐ Yes ☐ No	
List operations		
Other medical history: Have you—		
been admitted to hospital?	☐ Yes ☐ No	
been rejected for life insurance?	☐ Yes ☐ No	
failed a medical examination?	☐ Yes ☐ No	
been unable to work on medical grounds?	☐ Yes ☐ No	
any other illness or health problem?	☐ Yes ☐ No	
Family history		
Is there any family history of heart disease?	☐ Yes ☐ No	
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	
Females only		
Are you now pregnant or planning to be?	☐ Yes ☐ No	
Do you have periods which incapacitate you or which may reduce your physical or mental performance?	☐ Yes ☐ No	

I hereby authorize the examining doctor to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signed ______________________________ Date ________________

END OF QUESTIONNAIRE - Please hand to reception

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