



**Medical Questionnaire
Dive Medical Recreational AS4005.1**

Please complete the following

Section 1		
1	Surname:	Given Names
2	Date of Birth: / /	Sex: Male / Female
3	Address:	
4	Suburb:	State: Postcode
5	Home Phone: ()	Business Phone: () Mobile:
6	Occupation:	

Section 2			Details
1	Do you participate in regular physical activity?	Yes / No	
2	Description of activity:		
3	Do you smoke cigarettes?	Yes / No	
4	How many cigarettes do you smoke per day?		
5	Have you been a smoker in the past?	Yes / No	
6	Do you drink alcohol?	Yes / No	
7	How many drinks per week (average)?		
8	Do you take any tablets, medicines or drugs?	Yes / No	
9	List medications taken:		
	1) 2)		
	3) 4)		
10	Do you have any allergies?	Yes / No	
11	Have you ever had any reactions to drugs, medicines or foods?	Yes / No	

Section 3			Notes on history
1	Previous diving medical	Yes / No	
2	Prescription spectacle	Yes / No	
3	Contact lenses	Yes / No	
4	Eye or visual problem	Yes / No	
5	Denture/plates, dental prosthesis	Yes / No	
6	Recent dental procedure	Yes / No	
7	Hay Fever	Yes / No	
8	Sinusitis	Yes / No	

Section 3 Continued			Notes on history
9	Any other nose or throat problem	Yes / No	
10	Deafness or ringing noises in the ear	Yes / No	
11	Ear infections or discharge from the ear	Yes / No	
12	Giddiness or loss of balance	Yes / No	
13	Operation on the ear	Yes / No	
14	Severe motion sickness	Yes / No	
15	Need to take seasickness medication	Yes / No	
16	Any problems when flying in aircraft	Yes / No	
17	Severe or frequent headaches	Yes / No	
18	Migraine	Yes / No	
19	Fainting or blackouts	Yes / No	
20	Convulsions, fits or epilepsy	Yes / No	
21	Unconsciousness	Yes / No	
22	Head injury or concussion	Yes / No	
23	Sleepwalking	Yes / No	
24	Severe depression	Yes / No	
25	Claustrophobia	Yes / No	
26	Mental illness	Yes / No	
27	Heart disease	Yes / No	
28	Abnormal blood test	Yes / No	
29	ECG (heart tracing)	Yes / No	
30	Palpitations or consciousness of your heartbeat	Yes / No	
31	High blood pressure	Yes / No	
32	Rheumatic fever	Yes / No	
33	Pain or discomfort in the chest on exertion	Yes / No	
34	Shortness of breath on exertion	Yes / No	
35	Bronchitis or pneumonia	Yes / No	
36	Pleurisy or severe chest pain	Yes / No	
37	Coughing up blood or phlegm	Yes / No	
38	Chronic or persistent cough	Yes / No	
39	TB	Yes / No	
40	Pneumothorax (collapsed lung)	Yes / No	
41	Frequent chest colds or flu	Yes / No	
42	Asthma or wheezing	Yes / No	
43	Need to use a puffer or inhaler	Yes / No	
44	Operation on chest, lungs or heart	Yes / No	
45	Other chest complaint	Yes / No	
46	Indigestion, acid reflux or peptic ulcer	Yes / No	
47	Vomiting blood or passing red or black bowel motions	Yes / No	
48	Recurrent vomiting or diarrhoea	Yes / No	
49	Jaundice, hepatitis or liver disease	Yes / No	
50	Malaria or other tropical disease	Yes / No	

Section 3 Continued			Notes on history
51	Severe loss of weight	Yes / No	
52	Hernia or rupture	Yes / No	
53	Back injury	Yes / No	
54	Significant joint problem or sports injury	Yes / No	
55	Limitation of movement	Yes / No	
56	Fracture (broken bones)	Yes / No	
57	Paralysis or muscle weakness	Yes / No	
58	Kidney or bladder diseases	Yes / No	
59	In a high risk group for AIDS or HIV	Yes / No	
60	Syphilis	Yes / No	
61	Diabetes	Yes / No	
62	Sickle cell disease	Yes / No	
63	Bleeding problem or other blood disease	Yes / No	
64	Skin disease	Yes / No	
65	Contagious disease	Yes / No	
66	Operations	Yes / No	
67	Admitted to hospital for any reason	Yes / No	
68	Rejected for life insurance	Yes / No	
69	A job or a licence refused on medical grounds	Yes / No	
70	Unable to work on medical grounds	Yes / No	
71	An invalid pension	Yes / No	
72	any other illness or health problem	Yes / No	
73	Family History of heart disease	Yes / No	
74	Family history of asthma or chest disease	Yes / No	
75	Family history of tuberculosis or TB	Yes / No	
76	Date of last chest xray	Yes / No	
Females only		Yes / No	
77	Are you now pregnant or planning to be	Yes / No	
78	Do you have periods which incapacitate you or which may reduce your physical or mental performance	Yes / No	

Section 4			Notes
Previous diving experience		Yes / No	
1	Can you Swim?	Yes / No	
2	Have you ever had any problems during or after swimming or diving?	Yes / No	
3	Have you ever had to be rescued?	Yes / No	
4	Do you snorkel or dive regularly?	Yes / No	
5	Have you tried SCUBA diving before?	Yes / No	
6	Have you ever had formal scuba training?	Yes / No	
	Year:	Yes / No	

Section 4 Continued		Notes
7	Approximate number of dives:	
8	Maximum depth of any dive:	
9	Longest duration of any dive:	

I certify that this information is true and complete to the best of my knowledge and I hereby authorise Dr _____ to give medical opinion as to my fitness or temporary or permanent unfitness to dive to my diving instructor. I also authorise him or her to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest

Signature:

Date: / /

To Be Completed by A Registered Medical Practitioner							Notes	
1	Height:							
2	Weight:							
3	Vision	Right Uncorrected 6/						
		Left Uncorrected 6/						
		Right Corrected 6/						
		Left Corrected 6/						
4	Blood pressure /							
5	Pulse / minute							
6	Urinalysis	Albumin: Neg / Pos						
		Glucose: Neg / Pos						
7	PFT	FEV1						
		FVC						
		%						
8	Chest x ray (if indicated)	Date / /						
		Place:						
		Result:						
9	Audiometry (air conduction)	500	1000	2000	4000	6000		8000
	Frequency							
	Loss in dB - Right							
	Loss in dB - Left							
10	Nose, septum, airway	Normal			Abnormal			
11	Mouth, throat, teeth, bite	Normal			Abnormal			
12	External auditory canal	Normal			Abnormal			
13	Tympanic membrane	Normal			Abnormal			
14	Middle ear auto inflation	Normal			Abnormal			
15	Neurological eye movements	Normal			Abnormal			
16	Neurological Pupillary reflexes	Normal			Abnormal			
17	Neurological limb reflexes	Normal			Abnormal			
18	Neurological - Finger-Nose	Normal			Abnormal			
19	Neurological Sharpened Romberg*	Normal			Abnormal			
20	Abdomen	Normal			Abnormal			
21	Chest Hyperventilation	Normal			Abnormal			
22	Cardiac Auscultation	Normal			Abnormal			
23	Other abnormalities	Normal			Abnormal			

*Results should be descriptively detailed at right to assist future comparison

General Comments	

Examination Summary			
Fitness to dive certification	YES	Special Advice:	
	NO	Temporary Reason:	
	NO	Permanent Reason:	

Medical Officer

Print Name

Signature

.....

.....

Date / /

.....

.....

Date / /