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Dive Medical Recreational AS 4005.1 - Medical Questionnaire

Section: 1				
1	Surname:		Given names:	
2	Date of birth: / /		Sex: ☐ M ☐ F	
3	Address:			
4	Suburb:		State:	Postcode:
5	Home phone number:	Business phone number:		Mobile phone number:
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:			
10	1) 3)			
11	2) 4)			
12	Do you have any allergies?	☐ Yes	☐ No	
13	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 spectacles	☐ 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	

Section: 3 *(continued)*				*Notes on history*
7	Hay fever	☐ Yes	☐ No	
8	Sinusitis	☐ Yes	☐ No	
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	
Section: 3 *(continued)*				*Notes on history*
48	Recurrent vomiting or diarrhoea	☐ Yes	☐ No	
49	Jaundice, hepatitis or liver disease	☐ Yes	☐ No	
50	Malaria or other tropical disease	☐ Yes	☐ No	
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	
67	Operations	☐ Yes	☐ No	
68	Admitted to hospital for any reason	☐ Yes	☐ No	
69	Rejected for life insurance	☐ Yes	☐ No	
70	A job or a licence refused on medical grounds	☐ Yes	☐ No	
71	Unable to work on medical grounds	☐ Yes	☐ No	
72	An invalid pension	☐ Yes	☐ No	
73	Any other illness or health problem	☐ Yes	☐ No	
74	Family history of heart disease	☐ Yes	☐ No	
75	Family history of asthma or chest disease	☐ Yes	☐ No	
76	Family history of tuberculosis or TB	☐ Yes	☐ No	
77	Date of last chest x ray	/	/	
Females only				
78	Are you now pregnant or planning to be	☐ Yes	☐ No	
79	Do you have periods which incapacitate you or which may reduce your physical or mental performance	☐ Yes	☐ No	

Section: 4				*Notes*
Previous diving experience				
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	
Section: 4 *(continued)*				*Notes*
5	Have you tried SCUBA diving before?	☐ Yes	☐ No	
6	Have you ever had formal scuba training?	☐ Yes	☐ No	
7	Year:			
8	Approximate number of dives:			
9	Maximum depth or any dive:			
10	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:	/min						
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)							
	Frequency	500	1000	2000	4000	6000	8000	
	Loss in dB - Right							
	Loss in dB - Left							

** If abnormal enter on certificate, in logbook or both.*

Clinical Assessment:				*Notes*
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 (General Practitioner):

Doctor's signature:……. Date: / /

Doctor's name (print): ……