ROYAL ADELAIDE HOSPITAL

PATIENT LABEL

Unit Record No.: _____

Surname: _____

Given Names: _____

Date of Birth: _____ Sex: _____

Section A: Personal details

(Candidate to complete prior to appointment with Doctor)

Surname _____ Given Name _____

Sex: Male Female Date of Birth: _____ / _____ / _____

Country of Birth _____ Occupation _____

Current Address _____

_____

Home Phone Number _____ Business Phone Number _____

Next of Kin (name) _____ Relationship _____

Address _____

Home Phone Number _____ Business Phone Number _____

Section B: Medical History

	Question	Yes	No	Doctor's Comments
1.	Have you ever had a diving medical before? **If yes, what was the outcome?** **Pass Fail Restrictions applied**			
2.	How often do you undertake significant physical activity? (Circle correct response) Rarely <1/week Weekly 2-3/week Most days			
3.	What type of physical activity do you undertake? (e.g. walking, swimming, running)			
4.	Have you ever smoked cigarettes?	**Yes**	**No**	
5.	How many cigarettes do you smoke per day? Number			
6.	Do you drink alcohol?	**Yes**	**No**	
7.	How many drinks per week (average)?	Number =		
8.	Do you take any tablets, medicines or drugs? (Include over the counter medications)	**List**		
9.	Have you had any reaction to medicines or drugs or foods?	**Yes**	**No**	

	Have you ever had, or do you now have or suffer from any of the following:			
		YES	NO	Doctor's Comments
10.	Eye or visual problems			
11.	Prescription spectacles			
12.	Contact lenses			
13.	Dentures or plate			
14.	Recent dental procedure			
15.	Hay fever			
16.	Sinusitis			
17.	Nosebleeds			
18.	Deafness or ringing noises in the ear			
19.	Ear infections or discharge from the ear			
20.	Giddiness or loss of balance			
21.	Operation on the ear			
22.	Other ear, nose or throat problem			
23.	Severe motion sickness			
24.	Need to take seasickness medication			
25.	Problems with ears or sinuses when flying in aircraft			
26.	Severe or frequent headaches			
27.	Migraine			
28.	Fainting or blackouts			
29.	Convulsions, fits or epilepsy			
30.	Unconsciousness			
31.	Head injury or concussion			
32.	Numbness or altered sensation			
33.	Sleepwalking			
34.	Severe depression			
35.	Claustrophobia			
36.	Mental illness			
37.	Heart Disease			
38.	Abnormal blood test			
39.	Abnormal ECG			
40.	Palpitations or consciousness of your heartbeat			
41.	High blood pressure			
42.	Rheumatic fever			
43.	Pain or discomfort in the chest on exertion			
44.	Excessive shortness of breath			
45.	Bronchitis or pneumonia			
46.	Pleurisy or severe chest pain			
47.	Coughing up blood or phlegm			
48.	Chronic or persistent cough			
49.	TB			
50.	Pneumothorax			
51.	Frequent chest colds or flu			
52.	Asthma or wheezing			
53.	Need to use puffer or inhaler			
54.	Operation on chest, heart or lungs			
55.	Other chest complaint			
56.	Indigestion, acid reflux or peptic ulcer			
57.	Vomiting blood or passing red or black bowel motions			
58.	Recurrent vomiting or diarrhoea			
59.	Jaundice, hepatitis or liver disease			
60.	Malaria or other tropical disease			
61.	Severe loss of weight			

ROYAL ADELAIDE HOSPITAL

AS/NZS 2299 DIVING MEDICAL EXAMINATION – MEDICAL QUESTIONNAIRE

PATIENT LABEL

Unit Record No.: _____

Surname: _____

Given Names: _____

Date of Birth: _____ Sex: _____

	Question	Yes	No	Doctor's Comments
	Have you ever had, or do you now have or suffer from any of the following: continued			
62.	Hernia or rupture			
63.	Back injury			
64.	Significant joint problem or sports injury			
65.	Limitation of movement			
66.	Fracture			
67.	Paralysis or muscle weakness			
68.	Kidney or bladder disease			
69.	Diabetes			
70.	Sickle cell disease			
71.	Bleeding problem or other blood disease			
72.	Skin Disease			
73.	Contagious Disease			
74.	Operations/Hospital admissions List Operations/admissions			
75.	Rejected for life insurance			
76.	Failed a medical examination			
77.	Unable to work on medical grounds			
78.	Any other illness or health problem			
79.	Family history of heart disease			
80.	Family history of asthma or chest disease			
81.	**Females only** Are you now pregnant or planning to be pregnant?			
82.	Do you have periods which incapacitate you or which may reduce your physical or mental performance?			

Diving history?

	Question	Yes	No	Doctor's Comments
	Have you ever suffered from:			
83.	Ear squeeze?			
84.	Sinus squeeze?			
85.	Decompression illness?			
86.	Headaches during or after dive?			
87.	Extreme tiredness after dive?			
88.	Any other diving related problems?			

I certify that the above information is true and complete to the best of my knowledge.

Signed: _____ Date: _____

SECTION C: Medical Examination Findings

Physical Assessment

				Doctor's Comments
1. BUILD	Height CM	Weight Kg	BMI	
2.	Blood Pressure . /	Pulse /Min		
3. VISION Distance (Snellen)	Unaided L)_____ R)_____ Aided L)_____ R)_____			
Near (Times Roman)	Unaided L)_____ R)_____ Aided L)_____ R)_____			
4. URINALYSIS	Normal Abnormal			

	AREA ASSESSED	NORMAL	ABNORMAL	DOCTOR'S COMMENTS
5.	Colour Vision (Ishihara)			
6.	Head, Scalp, Face, Neck			
7.	Ophthalmoscopy			
8.	Pupils			
9.	Eye movements			
10.	Visual fields			
11.	Nose, septum, airway, sinuses			
12.	Mouth nose throat, speech			
13.	Ears external			
14.	Tympanic membranes R			
15.	Tympanic membranes L			
16.	Chest and lung fields			
17.	Cardiac auscultation			
18.	Abdomen			
19.	Lymph Nodes			
20.	Posture and gait			
21.	Spine			
22.	Upper limbs			
23.	Lower limbs			
24.	Sensation			
25.	Cerebellar functions			
26.	Audiometry			
27.	Emotional & psychiatric stability			

		Easy with Valsalva	With difficulty/ alternative manoeuvres	Nil Unsatis-factory	
28.	Eustachian tubes R				
	Eustachian tubes L				

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	Tendon reflexes	Doctor's Comments
29.	**Tendon Reflexes:** Absent Weak Mid-Range Brisk Hyperreflexic Biceps R _____ Biceps L _____ Triceps R _____ Triceps L _____ B/Rad R _____ B/Rad L _____ Knee R _____ Knee L _____ Ankle R _____ Ankle L _____ (Mark line to indicate strength of reflex elicited)	

	Peripheral Pulses	Present	Absent	
30.	**R Dorsalis Pedis**			
	L Dorsalis Pedis			
	R Post Tibial			
	L Post Tibial			

31.	Exercise tolerance	Tick box(s)	Results	
	Fitness Good based on history			
	Fitness Acceptable based on history			
32.	Exercise test requested	Date		
	Exercise test performed	Date		

33. Lung function

Spirometry (initial assessment undertaken at lung function laboratory for pre/post bronchodilator)
Subsequent yearly spirometry without bronchodilator undertaken at OHS&IM

	MEASURED	PREDICTED	PERCENTAGE
FVC			
FEV1			
FEV1/FVC			
COMMENTS			

	Tests	Required	Not required	Results
34.	CXR (Initial assessment then 5 yearly or as clinically indicated)			
35.	ECG (Initial assessment then 5 yearly or as clinically indicated)			
36.	Serum Lipids (RAH Staff on initial only)			

37.. Sharpened Rhomberg Test

R foot forward number of falls time stable.....secs

L foot forward number of falls time stable.....secs

(Circle one) very stable few minor sways/wobbles moderately unsteady

Minor swaying/wobbles unable to hold balance

	Area assessed	Doctor's Comments
38.	**Other abnormalities**	

Comments: _____