

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					
Approx. date of first compressed air dive.....					
Total hours under pressure					
Types of diving experience:					
<input type="checkbox"/> Scuba air		<input type="checkbox"/> Surface supply		<input type="checkbox"/> Saturation	
<input type="checkbox"/> Scuba mix gas		<input type="checkbox"/> Surface deco		<input type="checkbox"/> Oxygen	
<input type="checkbox"/> Hookah		<input type="checkbox"/> Bell diving			
How many dives to date					
Longest dive					
Deepest dive					
Have you ever suffered from—					
ear squeeze?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
sinus squeeze?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
decompression illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
headaches during or after dive?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
extreme tiredness after dive?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Any other diving-related problems?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, specify					

Doctor's use only

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

Hernia or rupture Yes No

Candidate's name

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

Doctor's use only

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

Candidate's name

AS/NZS 2299.1 Occupational Diving Medical Examination—To be Completed by a Doctor Trained in Underwater Medicine

General appearance

Visual acuity	Uncorrected	Corrected	Near vision	Colour perception	Height	Weight
Right	6/	6/			cm	kg
Left	6/	6/				
Waist measurement (cm)		Hip measurement (cm)		Ratio (W/H)		
BP	/	Pulse	/Min	Urinalysis		

		Notes and comments	
Head, Scalp, Face, Neck		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Ophthalmoscopy.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Pupils.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eye movements		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Visual fields.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Nose, Septum, Airway, Sinuses		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mouth, Throat, Teeth, Speech.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Ears—external.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Tympanic membrane	R	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	L	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eustachian tubes	R	<input type="checkbox"/> Easily with Valsalva	<input type="checkbox"/> With difficulty/alternate manoeuvres
		<input type="checkbox"/> Nil/Unsatisfactory	
(ear clearing)	L	<input type="checkbox"/> Easily with Valsalva	<input type="checkbox"/> With difficulty/alternate manoeuvres
		<input type="checkbox"/> Nil/Unsatisfactory	
Chest & lung fields.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Cardiac auscultation		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Abdomen		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Lymph nodes.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Posture & gait.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Spine.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Upper limbs.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Lower limbs.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Peripheral pulses.....		<input type="checkbox"/> Right Dorsalis Pedis	<input type="checkbox"/> Left Dorsalis Pedis
		<input type="checkbox"/> Right Post Tibial	<input type="checkbox"/> Right Post Tibial

Tendon reflexes	Absent	Weak	Mid-range	Brisk	Hyperreflexic	Notes and comments
Biceps	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Triceps	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
B/Rad	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Knee	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Ankle	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____

(mark line to indicate strength of reflex elicited)

Plantar reflexes Right Left.....

AS/NZS 2299.1 Occupational Diver Medical Fitness Certificate

I, _____, certify that

(Doctor's name)

(Candidate's name)

has been assessed for medical fitness to dive in accordance with AS/NZS 2299.1:2015 and has been found—

- Fit to dive/work under pressure**
- Permanently unfit**
- Temporarily unfit—Review date**
- Decision pending**

Categories of occupational diving for which fitness was assessed:

- All occupational diving**
- All occupational diving except saturation**
- Other**

Advice provided:

Comments:

I confirm that I have received formal training in the conduct of occupational diving medical examinations.

Signed

Doctor's name (print)

Date

Candidate's signature