

## DIVER MEDICAL | PARTICIPANT QUESTIONNAIRE

Recreational scuba diving and freediving require good physical and mental health. There are a few medical conditions that can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education or fun diving.

**Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course. If you answer 'yes' to any statement below, you must get the Physician's Evaluation Form duly filled out and signed by a registered doctor.**

**FOR YOUR SAFETY, AND THAT OF OTHERS WHO MAY DIVE WITH YOU, ANSWER ALL STATEMENTS HONESTLY.**

**NOTE TO WOMEN:** If you are pregnant, or attempting to become pregnant, do not dive.

MEDICAL STATEMENTS	YES/NO
I am over 50 years of age	
I am over 45 years of age <b>AND</b> answer yes to either or both of the following statements: <ul style="list-style-type: none"> <li>• I currently smoke or inhale nicotine by other means</li> <li>• I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy)</li> </ul>	
I have a cold or am currently coughing	
I have / had asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise OR I currently use an inhaler	
I have / had recurrent sinusitis, bronchitis, emphysema, pneumothorax (collapsed lung), chronic lung disease or any other problem with my lungs/breathing	
I have / had a problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or had a chest surgery, heart surgery, heart valve surgery or am taking medication for any heart condition	
I struggle to perform moderate exercise (for example, walk 1.6 kilometres/1 mile in 14 minutes or swim 200 metres/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons	
I have a high cholesterol level	
I have / had a problem with my blood or have a high / low blood pressure	
I have had a surgery within the last 2 years or I have ongoing problems related to past surgery	

I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than Mefloquine/Lariam)	
I have an implantable medical device in my body (eg, stent, pacemaker, screw, rod, neurostimulator, etc.)	
I have / had ear disease, ear surgery, hearing loss or problems with balance	
I had an injury within the past 2 years that has / had restricted my movement (eg, fracture, injury of neck, shoulder, back, joints, ligament tears, etc.)	
I have had head injury with loss of consciousness	
I have / had blackouts or fainting (full / partial loss of consciousness), recurring migraine headaches, epilepsy, seizures, convulsions or stroke or am taking medications to prevent them	
I have / had persistent neurologic injury or disease	
I am currently undergoing (or have required treatment within the last 5 years) for psychological problems including major depression, suicidal ideation, uncontrolled bipolar disorder, personality disorder, panic attacks, or for an addiction to drugs or alcohol	
I have been diagnosed with a learning / developmental disorder	
I have / had recurrent back problems, uncorrected hernia, active or untreated ulcers, problem wounds or diabetes – either insulin- or diet-controlled or gestational diabetes	
I have / had dehydration requiring medical intervention within the last 7 days	
I have / had stomach or intestine problems, including recent diarrhoea requiring medication	
I have / had frequent heartburn, regurgitation or gastroesophageal reflux disease (GERD)	
I have / had active or uncontrolled ulcerative colitis or Crohn’s disease	

**PARTICIPANT STATEMENT**

I have answered all questions honestly, and understand that I accept responsibility for any consequence resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

\_\_\_\_\_

(Participant Name)

\_\_\_\_\_

Date of birth (dd/mm/yyyy)

\_\_\_\_\_

(Participant Signature)

\_\_\_\_\_

Date (dd/mm/yyyy)

\_\_\_\_\_

(Parent/guardian signature in case of minor participant)

\_\_\_\_\_

Date (dd/mm/yyyy)

**DIVER MEDICAL | PHYSICIAN'S EVALUATION FORM**

Participant Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**The above-named person requests your opinion of her/his medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit [uhms.org](http://uhms.org) for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.**

**Evaluation Result**

Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving

Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Date (dd/mm/yyyy)

Name : \_\_\_\_\_

Specialty : \_\_\_\_\_

Clinic/Hospital : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone : \_\_\_\_\_ Email : \_\_\_\_\_

**Physician/Clinic Stamp**

