



Medical examination / assessment of Sport Divers (confidential information)

- Please complete all relevant sections and tick box(es) where appropriate.
 - Write clearly and please print.
- Completed forms should be send with application and a copy should be saved by the Diver.

Diver's personal details:

Last name First name

Date of Birth Sex: Female () Male ()

Address

Nationality Level of Disability

Type of Medical:

Preliminary Examination() Renewal Examination ()

Date of examination Date of expiry

Is the diver medically fit to dive? Yes () No ()

If Yes, are there any restrictions? Yes () No ()

If Yes, please explain

Examining Doctor's details:

Name

Stamp

Address

Date

Signature _____

In order to participate in diving activities you are required to read this statement, complete and sign this form and have a physician fill out and sign the section on page 1.

Before you become engaged with scuba diving activities it is important that you are aware of some of the potential risks involved. Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When however, established safety procedures are not followed there are dangers.

To scuba dive safely, you should endeavour to maintain good health. Avoid being excessively overweight, and avoid being in poor physical condition. All your body air spaces must be effective and healthy. A person who suffers from any severe medical problem, is in ill health, or does not feel well should not dive. If you are taking medication, consult your doctor and your instructor before participating in any activity.

Your instructor will teach you the important safety rules regarding scuba diving. Improper use of scuba equipment can result in serious injury. In order to dive safely you must be thoroughly familiar with your equipment and know how to use it correctly.

General Information.

Are you a swimmer? Yes () No ()
Do you have snorkelling/diving experience? Yes () No ()
Do you have any swimming, snorkelling or diving diploma's? Yes () No ()

Medical History.

Please answer the following questions regarding your past and/or present medical history with a YES or NO. If you are uncertain, answer YES. If you do not understand the question please ask your instructor or doctor to explain.

For your own safety and in accordance with IAHD standards, you are required to consult with a physician prior to participating in scuba diving. Please complete all three pages prior to your medical examination. Take this form with you to your physician so that after examining you, she/he may complete and sign the section on page 1 of this form.

Could you be pregnant or are you attempting to become pregnant? Yes () No ()
Do you regularly take prescription or non prescription medications? Yes () No ()
(with exception of birth control)
Are you over 45 years of age and have one or more of the following:
Currently smoke a pipe, cigar or cigarette? Yes () No ()
Have a high cholesterol level? Yes () No ()
Have a family history of heart attacks or strokes? Yes () No ()
If you are disabled through illness or injury, how long ago did it happen? _____

Should you answer YES to any of the questions below, please give a brief explanation where necessary.

Do you:
Use a catheter? _____ Type: _____
Have any time had decubitus ulcers (pressure sores)? _____ If YES, when? _____
Present condition? _____
Have a respiratory disorder? _____ If YES, explain: _____
Have any problems with your ability to perspire? _____ If YES, explain: _____
Suffer from heat loss problems, thermoregulation? _____ If YES, explain: _____
Have any loss of muscle control in the mouth or lips? _____ If YES, explain: _____
Suffer from spasms? _____
Suffer from Deep Vein Thrombosis (DVT)? _____
Suffer from Dysreflexia? _____ If YES, can you treat yourself? _____
If not, will you have someone present who can? _____
Have any speech impairment? _____
Have any hearing loss? _____
Have any allergies? _____
Please state any other medical problem(s) not covered: _____

Have you ever had or do you currently suffer from:

Asthma or wheezing with breathing, or wheezing with exercise?	Yes	()	No	()
Frequent or severe attacks of hay fever?	Yes	()	No	()
Frequent colds, sinusitis or bronchitis?	Yes	()	No	()
Any form of lung disease?	Yes	()	No	()
Pneumothorax (collapsed lung)?	Yes	()	No	()
A history of chest surgery?	Yes	()	No	()
Claustrophobia or agoraphobia (fear of closed or open spaces)?	Yes	()	No	()
Behavioural health problems?	Yes	()	No	()
Epilepsy, seizures, convulsions or take medication to prevent them?	Yes	()	No	()
Recurring migraine headaches or take medication to prevent them?	Yes	()	No	()
A history of blackouts or fainting (full/partial loss of consciousness)?	Yes	()	No	()
Motion sickness (seasick, carsick, etc.)?	Yes	()	No	()
Problems with your cough reflex or intercostal muscles?	Yes	()	No	()
A history of diving accidents or decompression sickness?	Yes	()	No	()
A history of recurrent back problems?	Yes	()	No	()
A history of back surgery?	Yes	()	No	()
A history of diabetes?	Yes	()	No	()
Any back, arm or leg problems after surgery, injure or fracture?	Yes	()	No	()
An inability to perform moderate exercises?	Yes	()	No	()
Any high blood pressure or take medication for controlling it?	Yes	()	No	()
A history of any heart attacks?	Yes	()	No	()
Angina or heart surgery or blood vessel surgery?	Yes	()	No	()
A history of heart disease?	Yes	()	No	()
A history of ear or sinus surgery?	Yes	()	No	()
A history of ear disease, hearing loss or problems with balance?	Yes	()	No	()
Any problems equalising your ears with air or mountain travel?	Yes	()	No	()
A history of bleeding or other disorders?	Yes	()	No	()
Any loss of sensory responses (feeling)?	Yes	()	No	()
A history of any type of hernia?	Yes	()	No	()
A history of ulcers or ulcer surgery?	Yes	()	No	()
A history of drug or alcohol abuse?	Yes	()	No	()
A history of colostomy?	Yes	()	No	()

The information I have given above is accurate to the best of my knowledge.

Name: _____ Date: _____

signature

signature of parent or guardian if applicable