ADRENO
TRAINING & TRAVEL

ABN: 36 645 835 203

International and Domestic Medical Dive Assessment

DIVER MEDICAL | Participant Questionnaire

Recreational scuba diving and Freediving requires good physical and mental health. There are a few medical conditions which 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 have have a contagious disease, protect yourself and others by not 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. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite for any trips or recreational scuba diving, spearfishing or freediving courses.
Note to women: If you are pregnant, or attempting to become pregnant, do not dive.

1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.	Yes ☐ Go to Box A*	No ☐
2. I am over 45 years of age.	Yes ☐ Go to Box B*	No ☐
3. I struggle to perform moderate exercise (for example, walk 1.6 kilometres/ one mile in 14 minutes or swim 200 metres. years without resting), OR I have been unable to participate in normal physical activity due to fitness or health reasons within the past 12 months.	Yes ☐*	No ☐
4. I have had problems with my eyes, ears or nasal passages/sinuses.	Yes ☐ Go to Box C*	No ☐
5. I have had surgery within the last 12 months, OR have ongoing problems related to past surgery.	Yes ☐*	No ☐
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury or suffer from persistent neurologic injury or disease.	Yes ☐ Go to Box D*	No ☐
7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol: or, I have been diagnosed with a learning disability.	Yes ☐ Go to Box E*	No ☐
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ Go to Box F*	No ☐
9. I have had stomach or intestine problems, including recent diarrhoea.	Yes ☐ Go to Box G*	No ☐
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam.)	Yes ☐*	No ☐

Participant Signature

If you answered no to all questions above a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

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

Participant Signature (or, if a minor, participants parent/guardian signature required.)

Date (DD/MM/YY)

Participant Name (Print)

Birthdate (DD/MM/YY)

Instructor Name (Print)

Facilty Name (Print)

*If you answered yes to questions 3, 5 or 10 above OR to any of the questions on page 2, please read and agree to the statement above by signing and dating it AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician for a medical evaluation. Participation in a diving course requires your physicians approval.

Participant Name: _____ **Birthdate:** _____

(Print) Date (DD/MM/YY)

DIVER MEDICAL | Participant Questionnaire Continued

BOX A - I have/had:

Chest surgery, heart surgery, heart valve surgery, stent placement or a pneumothorax (collapsed lung)	Yes ☐* No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐* No ☐
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR are taking medication for any heart condition.	Yes ☐* No ☐
Recurrent bronchitis and currently coughing within the past 12 months, Or have been diagnosed with emphysema.	Yes ☐* No ☐
A diagnosis of COVID-19.	Yes ☐* No ☐

BOX B - I am over 45 years of age AND:

I currently smoke or inhale nicotine by other means.	Yes ☐* No ☐
I have high cholesterol level.	Yes ☐* No ☐
I have high blood pressure.	Yes ☐* No ☐
I have had a close blood relative due 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).	Yes ☐* No ☐

BOX C - I have/have had:

Sinus surgery within the last 6 months.	Yes ☐* No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐* No ☐
Recurrent sinusitis within the past 12 months	Yes ☐* No ☐
Eye surgery within the past 3 monhts.	Yes ☐* No ☐

BOX D - I have/have had:

Head Injury with loss of consciousness wthin the past 5 years.	Yes ☐* No ☐
Persistent neurologic injury or disease.	Yes ☐* No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐* No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years	Yes ☐* No ☐
Epliepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐* No ☐

BOX E - I have/have had:

Behavioural health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐* No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐* No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes ☐* No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐* No ☐

BOX F - I have/ have had:

Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐* No ☐
Back or spinal surgery within the last 12 months.	Yes ☐* No ☐
Diabetes, drug-or diet-controlled, OR gestational diabetes within the last 12 months.	Yes ☐* No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐* No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐* No ☐

BOX G - I have/had:

Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐* No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐* No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes ☐* No ☐
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD)	Yes ☐* No ☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes ☐* No ☐
Bariatric surgery within the last 12 months.	Yes ☐* No ☐

*Physician's medical evaluation required (see page 1)

DIVER MEDICAL | Participant Questionnaire Continued

Participant Name: _____ **Birthdate:** _____

(Print) Date (DD/MM/YY)

The above-named person requests your opinion of his/her medical suitability to participate in recereational scuba diving or freediving training or activity. Please visit 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.

Evalutation Result

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

☐ Approved - I find conditions that I consider incompatible with recreational scuba diving or freediving.

_____ _____

Physican's Signature Date (DD/MM/YY)

Physician's Name: _____ Speciality: _____

(Print)

Clinic/Hospital: _____

Address:

Phone: _____ Email: _____

Physician/Clinic Stamp (optional)