# **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 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. For your safety, and that of others who may dive with you, answer all questions honestly.

## Directions

**Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.**

**Note to women:** If you are pregnant, or attempting to become pregnant, *do not dive.*

**If you answer YES to any questions you will need to print this waiver from your email account AND have a physician complete the last page of waiver. Once completed email us the ENTIRE waiver to Info@CarolinaDiveCenter.com**

| | | |
|---|---|---|
| I have/have had: Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung). | Yes ☐* | No ☐ |
| I have/have had: Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise. | Yes ☐* | No ☐ |
| I have/have had A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition. | Yes ☐* | No ☐ |
| I have/have had: Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema. | Yes ☐* | No ☐ |
| I have/have had: A diagnosis of COVID-19. | Yes ☐* | No ☐ |
| I am over 45 years of age AND I currently smoke or inhale nicotine by other means. | Yes ☐* | No ☐ |
| I am over 45 years of age AND I have a high cholesterol level. | Yes ☐* | No ☐ |
| I am over 45 years of age AND I have high blood pressure. | Yes ☐* | No ☐ |
| 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). | Yes ☐* | No ☐ |
| I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months. | Yes ☐* | No ☐ |
| I have/have had: Sinus surgery within the last 6 months. | Yes ☐* | No ☐ |
| I have/have had: Ear disease or ear surgery, hearing loss, or problems with balance. | Yes ☐* | No ☐ |
| I have/have had : Recurrent sinusitis within the past 12 months. | Yes ☐* | No ☐ |
| I have/have had: Eye surgery within the past 3 months. | Yes ☐* | No ☐ |
| I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery. | Yes ☐* | No ☐ |
| I have/have had Head injury with loss of consciousness within the past 5 years. | Yes ☐* | No ☐ |
| I have/have had: Persistent neurologic injury or disease. | Yes ☐* | No ☐ |
| I have/have had: Recurring migraine headaches within the past 12 months, or take medications to prevent them. | Yes ☐* | No ☐ |
| I have/have ha: Blackouts or fainting (full/partial loss of consciousness) within the last 5 years. | Yes ☐* | No ☐ |
| I have/have had: Epilepsy, seizures, or convulsions, OR take medications to prevent them. | Yes ☐* | No ☐ |
| I have/have had: Behavioral health, mental or psychological problems requiring medical/psychiatric treatment in the past 5 years. | Yes ☐* | No ☐ |
| I have/have had: Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment. | Yes ☐* | No ☐ |
| I have been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care. | Yes ☐* | No ☐ |
| I have/have had: an addiction to drugs or alcohol requiring treatment within the last 5 years. | Yes ☐* | No ☐ |
| I have/have had: recurrent back problems in the last 6 months that limit my everyday activity. | Yes ☐* | No ☐ |
| I have/have had: Back or spinal surgery within the last 12 months. | Yes ☐* | No ☐ |
| I have/have had : Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months. | Yes ☐* | No ☐ |
| I have/have had: An uncorrected hernia that limits my physical abilities. | Yes ☐* | No ☐ |
| I have/have had: Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |
| I have/have had: Ostomy surgery and do not have medical clearance to swim or engage in physical activity. | Yes ☐* | No ☐ |
| I have/have had: Dehydration requiring medical intervention within the last 7 days. | Yes ☐* | No ☐ |
| I have/have had: Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |
| I have/have had: Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD). | Yes ☐* | No ☐ |
| I have/have had: Active or uncontrolled ulcerative colitis or Crohn's disease. | Yes ☐* | No ☐ |
| I have/have had: Bariatric surgery within the last 12 months. | Yes ☐* | No ☐ |
| I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam). | Yes ☐* | No ☐ |

***Physician's medical evaluation required**

# Participant Signature

**If you answered *NO*** to all questions, 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, participant's parent/guardian signature required.) | Date (dd/mm/yyyy) |
| Participant Name (Print) | Birthdate (dd/mm/yyyy) |
| Instructor Name (Print) | Facility Name (Print) |

*** If you answered *YES*** to any questions, please read and agree to the statement above by signing and dating it ***AND* take Participant Questionnaire and the Physician's Evaluation Form to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

**After your physician completes the evaluation form, email the completed Participant Questionnaire and Physicians Evaluation Form to us at INFO@CAROLINADIVECENTER.COM.**

# **Diver Medical** | Physician's Evaluation Form

Participant Name _____ Birthdate _____
(Print) Date (dd/mm/yyyy)

**The above-named person requests your opinion of his/her medical suitability to participate in recreational 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.**

## 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.

_____ _____
Physican's Signature Date (dd/mm/yyyy)

Physician's Name _____ Specialty _____
(Print)

Clinic/Hospital _____

Address

Phone _____ Email _____

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society
DAN (US)
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