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 enc… …reational sc… …ediving. This form is principally designed as an initial medical screen for new div… …opriate … …inuing education. For your safety, and that of others who may dive with you, … …nest…

If you answer YES to a question you must complete the listed BOX of questions on Page 2 .

If you answer NO to every question then all you have to do is a) sign and date page 1 AND print your name and date of birth on page 1.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba … …ed… …ou…

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 be… …osed 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 ki… … meters/yards without resting), OR I have been unable to participate … …al 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 I have ongoing …	Yes ☐*	No ☐
6. I have lost consciousness, had migraine headaches, seizures, stroke, … …ury, 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 th… …years) for psychological problems, personality disorder, panic attacks, or an addiction to drug… …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 diarrhea.	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 ☐

If you check yes to this question you must have a physician complete page 3

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Participant Signature

Make Sure You Complete Both The Signature Line AND Print your Name and Date of Birth on Line 2

If you ans… …stions above, a medical evaluation is not required. Please read and agree to the participant statement … …dating it.

Participant … …swered all questions honestly, and understand that I accept responsibility for any consequences … … any … …ons 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 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 physician's approval.

Participant Name _____ **Birthdate** _____

(Print) Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

Make sure you Print your name and date Page 2

If you answer YES to ANY question on Page 2 a physician must complete Page 3 of this form

Box A – I have/have had:		
Chest surgery, heart ... gery, stent placement, or a pneumoth...	Yes ☐*	No ☐
Asthma, wheezi... or congested airways within the last ... physical activity/exercise.	Yes ☐*	No ☐
A problem or illn... as: angina, chest pain on exertion, heart ... pulmonary edema, heart attack or stroke, OR am tak... rt condition.	Yes ☐*	No ☐
Recurrent bronchitis a... ing 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 a high cholesterol level.	Yes ☐*	No ☐
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 ☐

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 months.	Yes ☐*	No ☐

Box D – I have/have had:		
Head injury with loss of consciousness within 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 ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

Box E – I have/have had:		
Behavioral 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 | 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.

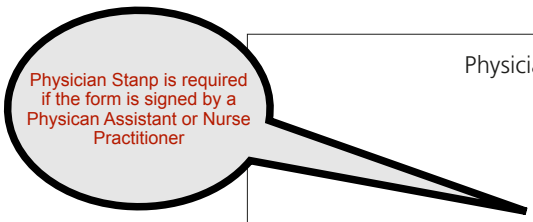
_____ _____
Physican's Signature Date (dd/mm/yyyy)

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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