



SOUTHERN MEDICAL SERVICES PTY LTD

### AS/NZS 2299 Diving Medical Examination – Medical Questionnaire

**Please complete the following:**

Surname		Given Names	
Date of Birth		Male	<input type="checkbox"/>
		Female	<input type="checkbox"/>
Address			
Suburb		State	Postcode
Home Phone No:	Business Phone No:		Mobile Phone No:
Occupation			

<b>Type of Medical</b>	
<input type="checkbox"/> Unrestricted – including saturation	<input type="checkbox"/> Limited Occupational Diving (Specify Type)
<input type="checkbox"/> Unrestricted – not including saturation	<input type="checkbox"/> Recreational Diving Industry work only.

Frequency of Significant Physical Activity	<input type="checkbox"/> Rarely	<input type="checkbox"/> < 1/week	<input type="checkbox"/> Weekly	<input type="checkbox"/> 2-3/week	<input type="checkbox"/> Most days
Type of Physical Activity					

How many cigarettes do you smoke per day?	Have you been a smoker in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many drinks per week (average)?
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Do you take any tablets, medicines or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List medications taken.	

Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Detail:	

Have you ever had any reactions to drugs, medicines, or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Detail:	

<b>Next of Kin</b> (Name):	Relationship:
Address:	
Phone Numbers:	

<b>Have you ever had, or do you now have or suffer from any of the following?</b>	<i>Doctor's use only</i>
Previous diving medical..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescription spectacles ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact lenses ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye or visual problem ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dentures or plate ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recent dental procedure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hayfever..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sinusitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nosebleeds ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Deafness or ringing noises in the ear ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ear infections or discharge from the ear ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Giddiness or loss of balance..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Operation on the ear ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other ear, nose or throat problem ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sever motion sickness..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Need to take seasickness medication ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with ears or sinuses when flying in aircraft <input type="checkbox"/> Yes <input type="checkbox"/> No	
Severe or frequent headaches..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Migraine..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fainting or blackouts..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Convulsions, fits or epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Unconsciousness ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Head Injury or concussion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleepwalking..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Severe depression..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Claustrophobia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental illness ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

*continued*

**AS/NZS 2299 Diving Medical Examination – Medical Questionnaire**

Abnormal blood test.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Doctor's use only</i>
ECG .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Palpitations or consciousness of heartbeat .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic fever .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain or discomfort in the chest on exertion....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shortness of breath on exertion.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bronchitis or pneumonia.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pleurisy or severe chest pain .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coughing up blood or phlegm.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic or persistent cough .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
TB .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumothorax .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent chest colds or flu .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma or wheezing.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Need to use a puffer or inhaler .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Operation on chest, lungs or heart.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other chest complaint .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Indigestion, acid reflux or peptic ulcer.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vomiting blood or passing red/black bowel motions .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent vomiting or diarrhoea .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Jaundice, hepatitis or liver disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Malaria or other tropical disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severe loss of weight .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hernia or rupture.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Back injury.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Significant joint problem or sports injury .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Limitation of movement.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fracture .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Paralysis or muscle weakness .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney or bladder disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sickle cell disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding problem or other blood disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	

*continued*

## AS/NZS 2299 Diving Medical Examination – Medical Questionnaire

Contagious disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Doctor's use only</i>	
Operations ..... <input type="checkbox"/> Yes <input type="checkbox"/> No List operations		
Admitted to hospital..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Rejected for life insurance ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Failed a medical examination..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Unable to work on medical grounds ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any other illness of health problem ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family history of heart disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family history of asthma or chest disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b><u>Females only</u></b>		
Are you now pregnant or planning to be..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have periods which incapacitate you or which may reduce your mental or physical performance ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b><u>Diving history to date</u></b>		
Approximate date of 1 <sup>st</sup> compressed air dive .....		
Total hours under pressure .....		
Types of diving experience		
<input type="checkbox"/> Scuba air <input type="checkbox"/> Surface supply <input type="checkbox"/> Saturation		
<input type="checkbox"/> Scuba mix gas <input type="checkbox"/> Surface deco <input type="checkbox"/> Oxygen		
<input type="checkbox"/> Hookah <input type="checkbox"/> Bell diving		
How many dives to date .....		
Longest dive .....		
Deepest dive .....		
Have you ever suffered from		
Ear squeeze? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sinus squeeze? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Decompression illness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Headaches during or after a dive?.... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Extreme tiredness after a dive?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any other diving related problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

*Candidate:.....*

## AS/NZS 2299 Diving Medical Examination – Examination Findings

General Comments
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Visual Acuity	Uncorrected	Corrected	Near Vision	Colour Perception	Height	Weight	BMI
Right	6/	6/			cm	kg	
Left	6/	6/					

**BP** /

**Pulse** /min

**Urinalysis**

	<i>Notes &amp; Comments</i>
Head, scalp, face & neck..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/unsatisfactory <input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/unsatisfactory
Ophthalmoscopy..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Pupils..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eye movements..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Visual fields..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Nose, Septum, Airway, Sinuses..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Mouth, Throat, Teeth, Speech..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Ears – external..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Tympanic membrane R..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
L..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eustachian tubes R..... <input type="checkbox"/> Easily with Valsava	
(ear clearing) L..... <input type="checkbox"/> Easily with Valsava	
Chest & lung fields..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Cardiac auscultation..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lymph nodes..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Posture & gait..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Spine..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Upper limbs..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lower limbs..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Peripheral pulses..... <input type="checkbox"/> R Dorsalis Pedis	
..... <input type="checkbox"/> L Dorsalis Pedis	
..... <input type="checkbox"/> R Post Tibial	
..... <input type="checkbox"/> L Post Tibial	

## AS/NZS 2299 Diving Medical Examination – Examination Findings

Tendon reflexes	Absent	Weak	Mid-range	Brisk	Hyperreflexic	Notes & Comments
Biceps	R	_____				
	L	_____				
Triceps	R	_____				
	L	_____				
B/Rad	R	_____				
	L	_____				
Knee	R	_____				
	L	_____				
Ankle	R	_____				
	L	_____				

*(mark line to indicate strength of reflex elicited)*

Sensation .....  Normal  Abnormal

Cerebellar Functions .....  Normal  Abnormal

Sharpened Romberg test

1 min	2 min	3 min	4 min	Total
				<b>/240</b>

Emotional & Psychiatric stability .....  Normal  Abnormal

Exercise tolerance .....  Fitness good – History

.....  Fitness acceptable – History

.....  Exercise test requested

.....  Exercise test performed (specify type & result)

Chest x-ray .....  Normal  Abnormal  Pending

Lung function .....  Normal  Abnormal  Pending

Spirometry

FEV	FVC	Ratio %

**AS/NZS 2299 Diving Medical Examination –Examination Findings**

Audiometry ..... Normal Abnormal Pending

	500	1000	1500	2000	3000	4000	6000	8000	HEARING STANDARD
L									
R									

Tympanometry ..... Normal Abnormal Pending

Long Bone Survey ..... Not indicated Recommended

Urinalysis

SG	Protein	Glucose	Blood	Other

Other tests ..... Nil required Indicated (specify)

Other abnormalities ..... Nil noted Noted (specify)

***Medical Fitness Recommendation***

- |   |  |
|---|--|
| <input type="checkbox"/> All occupational diving    | <input type="checkbox"/> Fit to dive/work under pressure       |
| <input type="checkbox"/> All except saturation      | <input type="checkbox"/> Permanently unfit                     |
| <input type="checkbox"/> Recreational industry only | <input type="checkbox"/> Temporarily unfit – Review date ..... |
| <input type="checkbox"/> Other .....                | <input type="checkbox"/> Decision pending                      |

**Comments:**

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**Signed** .....

**Doctor’s name(print)** .....

**Date:** .....

**Candidate:** .....