AS/NZS 2299.1 Occupational Diving Medical Examination—Medical Questionnaire

Please complete the following:

Surname Given names

Address

Date of birth Sex M F

Phone (home) Phone (work) Phone (mobile)

Occupation

Most recent dive medical date

Name of Diver's General Practitioner

Type of Medical

Unrestricted—including saturation Limited Occupational Diving—specify type.....

Unrestricted—not including saturation Recreational Diving Industry work only

Do you participate in any regular physical activity: Rarely <1/week Weekly 2–3/week Most days
Type of physical activity:

How many cigarettes do you smoke per day? Have you been a smoker in the past? Yes No

Do you drink alcohol? Yes No How many drinks per week (average)?

Do you take any tablets, medicines or drugs? Yes No
List:

In the past 12 months, have you consumed or smoked any illicit drugs? Yes No

Do you have any allergies? Yes No
List:

Have you ever had any reactions to drugs, medicines or foods? Yes No
List:

Next of kin name Relationship

Address

Phone number(s)

Diving history to date

Approx. date of first compressed air dive.....

Total hours under pressure .....

Types of diving experience:

☐ Scuba air ☐ Surface supply ☐ Saturation

☐ Scuba mix gas ☐ Surface deco ☐ Oxygen

☐ Hookah ☐ Bell diving

How many dives to date.....

Longest dive .....

Deepest dive.....

Have you ever suffered from—

ear squeeze? ..... ☐ Yes ☐ No

sinus squeeze? ..... ☐ Yes ☐ No

decompression illness? ..... ☐ Yes ☐ No

headaches during or after dive? ..... ☐ Yes ☐ No

extreme tiredness after dive? ..... ☐ Yes ☐ No

Any other diving-related problems? ..... ☐ Yes ☐ No

If yes, specify .....

Doctor's use only

Candidate's name.....

Have you ever had, or do you now have or suffer from, any of the following?		Doctor's use only
Prescription spectacles	☐ Yes ☐ No	
Contact lenses	☐ Yes ☐ No	
Eye or visual problem	☐ Yes ☐ No	
Dentures or plate	☐ Yes ☐ No	
Recent dental procedure	☐ Yes ☐ No	
Hay fever	☐ Yes ☐ No	
Sinusitis	☐ Yes ☐ No	
Nosebleeds	☐ Yes ☐ No	
Deafness or ringing noises in the ear	☐ Yes ☐ No	
Ear infections or discharge from the ear	☐ Yes ☐ No	
Giddiness or loss of balance	☐ Yes ☐ No	
Operation on the ear	☐ Yes ☐ No	
Other ear, nose or throat problem	☐ Yes ☐ No	
Severe motion sickness	☐ Yes ☐ No	
Need to take seasickness medication	☐ Yes ☐ No	
Problems with ears or sinuses when flying in aircraft	☐ Yes ☐ No	
Severe or frequent headaches	☐ Yes ☐ No	
Migraine	☐ Yes ☐ No	
Fainting or blackouts	☐ Yes ☐ No	
Convulsions, fits or epilepsy	☐ Yes ☐ No	
Unconsciousness	☐ Yes ☐ No	
Head injury or concussion	☐ Yes ☐ No	
Sleepwalking	☐ Yes ☐ No	
Severe depression	☐ Yes ☐ No	
Claustrophobia	☐ Yes ☐ No	
Mental illness	☐ Yes ☐ No	
Heart disease	☐ Yes ☐ No	
Abnormal blood test	☐ Yes ☐ No	
ECG	☐ Yes ☐ No	
Palpitations or consciousness of your heartbeat	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Rheumatic fever	☐ Yes ☐ No	
Pain or discomfort in the chest on exertion	☐ Yes ☐ No	
Shortness of breath on exertion	☐ Yes ☐ No	
Bronchitis or pneumonia	☐ Yes ☐ No	
Pleurisy or severe chest pain	☐ Yes ☐ No	
Coughing up blood or phlegm	☐ Yes ☐ No	
Chronic or persistent cough	☐ Yes ☐ No	
TB	☐ Yes ☐ No	
Pneumothorax	☐ Yes ☐ No	
Frequent chest colds or flu	☐ Yes ☐ No	
Asthma or wheezing	☐ Yes ☐ No	
Need to use a puffer or inhaler	☐ Yes ☐ No	
Operation on chest, lungs or heart	☐ Yes ☐ No	
Other chest complaint	☐ Yes ☐ No	
Indigestion, acid reflux or peptic ulcer	☐ Yes ☐ No	
Vomiting blood or passing red or black bowel motions	☐ Yes ☐ No	
Recurrent vomiting or diarrhoea	☐ Yes ☐ No	
Jaundice, hepatitis or liver disease	☐ Yes ☐ No	
Malaria or other tropical disease	☐ Yes ☐ No	
Severe loss of weight	☐ Yes ☐ No	

Hernia or rupture	☐ Yes ☐ No	

Candidate's name.....

Back injury	☐ Yes ☐ No	**Doctor's use only**
Significant joint problem or sports injury	☐ Yes ☐ No	
Limitation of movement	☐ Yes ☐ No	
Fracture	☐ Yes ☐ No	
Paralysis or muscle weakness	☐ Yes ☐ No	
Kidney or bladder disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Have you ever had, or do you now have or suffer from, any of the following?		
Sickle cell disease	☐ Yes ☐ No	
Bleeding problem or other blood disease	☐ Yes ☐ No	
Skin disease	☐ Yes ☐ No	
Contagious disease	☐ Yes ☐ No	
Operations	☐ Yes ☐ No	
List operations		
Other medical history: Have you—		
been admitted to hospital?	☐ Yes ☐ No	
been rejected for life insurance?	☐ Yes ☐ No	
failed a medical examination?	☐ Yes ☐ No	
been unable to work on medical grounds?	☐ Yes ☐ No	
any other illness or health problem?	☐ Yes ☐ No	
Family history		
Is there any family history of heart disease?	☐ Yes ☐ No	
Is there any family history of sudden death?	☐ Yes ☐ No	
Is there any family history of high cholesterol?	☐ Yes ☐ No	
Is there any family history of diabetes?	☐ Yes ☐ No	
Is there any family history of asthma or chest disease?	☐ Yes ☐ No	
Are you aware of any inherited diseases that run in your family?	☐ Yes ☐ No	
Females only		
Are you now pregnant or planning to be?	☐ Yes ☐ No	
Do you have periods which incapacitate you or which may reduce your physical or mental performance?	☐ Yes ☐ No	

I hereby authorize the examining doctor to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signed _____ Date_____

Candidate's name.....

AS/NZS 2299.1 Occupational Diving Medical Examination—To be Completed by a Doctor Trained in Underwater Medicine

General appearance

Visual acuity	Uncorrected	Corrected	Near vision	Colour perception	Height	Weight
Right	6/	6/			**cm**	**kg**
Left	6/	6/				

Waist measurement (cm) Hip measurement (cm) Ratio (W/H)

BP / **Pulse** /**Min** **Urinalysis**

		Notes and comments
Head, Scalp, Face, Neck	☐ Normal ☐ Abnormal	
Ophthalmoscopy	☐ Normal ☐ Abnormal	
Pupils	☐ Normal ☐ Abnormal	
Eye movements	☐ Normal ☐ Abnormal	
Visual fields	☐ Normal ☐ Abnormal	
Nose, Septum, Airway, Sinuses	☐ Normal ☐ Abnormal	
Mouth, Throat, Teeth, Speech	☐ Normal ☐ Abnormal	
Ears—external	☐ Normal ☐ Abnormal	
Tympanic membrane R	☐ Normal ☐ Abnormal	
L	☐ Normal ☐ Abnormal	
Eustachian tubes R	☐ Easily with Valsalva ☐ With difficulty/alternate manoeuvres ☐ Nil/Unsatisfactory	
(ear clearing) L	☐ Easily with Valsalva ☐ With difficulty/alternate manoeuvres ☐ Nil/Unsatisfactory	
Chest & lung fields	☐ Normal ☐ Abnormal	
Cardiac auscultation	☐ Normal ☐ Abnormal	
Abdomen	☐ Normal ☐ Abnormal	
Lymph nodes	☐ Normal ☐ Abnormal	
Posture & gait	☐ Normal ☐ Abnormal	
Spine	☐ Normal ☐ Abnormal	
Upper limbs	☐ Normal ☐ Abnormal	
Lower limbs	☐ Normal ☐ Abnormal	
Peripheral pulses	☐ Right Dorsalis Pedis ☐ Left Dorsalis Pedis ☐ Right Post Tibial ☐ Right Post Tibial	

Tendon reflexes		Absent	Weak	Mid-range	Brisk	Hyperreflexic	**Notes and 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)

Plantar reflexes Right..... Left.....

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Candidate's name .....

Sensation..... ☐ Normal ☐ Abnormal

Cerebellar functions ..... ☐ Normal ☐ Abnormal

Sharpened Romberg test Time stable.....(s) ☐ Very stable ☐ Major swaying/wobbles

☐ A few minor sways/wobbles ☐ Unable to hold balance

No. of attempts ..... ☐ Moderately unsteady

Emotional and psychiatric stability ☐ Normal ☐ Abnormal

Exercise tolerance..... ☐ Fitness good—History

☐ Fitness acceptable—History

☐ Exercise test requested

☐ Exercise test performed (specify type and result)

Chest X-ray..... ☐ Normal ☐ Abnormal Date..... Place .....

Lung function ..... ☐ Normal ☐ Abnormal

Vital capacity.....

FEV1.....

Percentage.....

Audiometry

	Frequency, Hz							
Hearing level	500	1000	1500	2000	3000	4000	6000	8000
dB (R)								
dB (L)								

Tympanometry ..... ☐ Normal ☐ Abnormal ☐ Pending

Long Bone Survey..... ☐ Not indicated ☐ Recommended

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

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

NOTES—INCLUDE RESULTS OF ANY TESTS AND RISK ASSESSMENTS HERE:

AS/NZS 2299.1 Occupational Diver Medical Fitness Certificate

I, _____, certify that

(Doctor's name)

_____

(Candidate's name)

has been assessed for medical fitness to dive in accordance with AS/NZS 2299.1:2015 and has been found—

- ☐ **Fit to dive/work under pressure**
- ☐ **Permanently unfit**
- ☐ **Temporarily unfit—Review date.....**
- ☐ **Decision pending.....**

Categories of occupational diving for which fitness was assessed:

- ☐ **All occupational diving**
- ☐ **All occupational diving except saturation**
- ☐ **Other .....**

Advice provided:

Comments:

I confirm that I have received formal training in the conduct of occupational diving medical examinations.

Signed .....

Doctor's name (print) .....

Date .....

Candidate's signature .....