Please read carefully before signing.

1. Surname _____ Other Names _____

2. Date of Birth (dd/mm/yyyy) _____

3. Address _____

_____

State: Postcode _____

4. Sex Male / Female

5. Telephone (Home) _____

6. Principal Occupation _____

7. Telephone (Work) _____

8. Email (Optional) _____

9. How often do you exercise (minutes per week)? _

What is your estimated level of intensity of that exercise (High-Medium-Low)?

_____

10. Are you taking any prescription tablets, medicines or drugs?

List: _____

_____

11. Have you had any reactions to drugs or medicines or foods?

Details: _____

12. Tobacco Smoking History.

Do you smoke tobacco now? Y/N

Have you ever smoked tobacco? Y/N

How many cigarettes per day do/did you smoke and for how many years?

_____

If other forms of tobacco, please detail_____

13. Do you drink alcohol?_____Y/N

Estimate how many standard drinks per night or week._____

_____

14. Do you currently consume illicit drugs? Y/N

Detail:_____

Please answer the following questions on your past or present medical history (from question 15 onwards) with a YES or NO.

- If you have never heard of the condition or had the diagnosis applied to you – then reply **NO**
- If you are not confident that you understand the question, then leave this blank and discuss with the doctor

Have you ever had or do you now have any of the following?	**YES**	**NO**	**Physician's comments**
15. Any continuing eye or visual problems (apart from needing glasses or contact lenses)?			
16. Sinusitis (e.g. hay fever, sinus infections)?			
17. Any other nose or throat problem (apart from previous coughs and colds)?			
18. Dentures or plates that are removable?			
19. Deafness or ringing noises in ear(s)?			
20. Discharging ears or other infections?			
21. Previous ear operation (including as a child)?			
22. Giddiness or loss of balance?			
23. Severe motion sickness?			
24. Any ear problems or severe headaches when flying in aircraft?			
25. Severe or frequent headaches, including migraine?			
26. Faints or blackouts?			
27. Convulsions, fits or epilepsy?			
28. Any episodes of unconsciousness?			
29. Depression requiring medical treatment?			
30. Claustrophobia?			
31. Mental illness or mental health issues requiring therapy of treatment?			
32. Bronchitis or pneumonia?			
33. Pleurisy or severe chest pain?			
34. Coughing up phlegm or blood?			

Have you ever had or do you now have any of the following?	YES	NO	Physician's comments
35. Chronic or persistent cough?			
36. Tuberculosis ("TB")?			
37. Pneumothorax ("collapsed lung")?			
38. Frequent chest colds?			
39. Asthma or wheezing?			
40. Use a puffer (medication inhaler for asthma)?			
41. Any other chest complaint?			
42. Operation on chest, lungs, or heart?			
43. Peptic ulcer or acid reflux requiring treatment?			
44. Vomiting blood or passing red or black motions?			
45. Jaundice, hepatitis or liver disease?			
46. Malaria?			
47. Severe loss of weight?			
48. Hernia or rupture?			
49. Major joint or back injury?			
50. Paralysis, muscle weakness or numbness?			
51. Kidney disease?			
52. Diabetes?			
53. Blood disease or bleeding problem?			
54. Could you be pregnant, or are you trying to become pregnant?			
CARDIOVASCULAR RISK QUESTIONS			
55. Do you have any known heart disease or have your ever consulted a cardiologist (specialist heart doctor)?			
56. Is there a family history of heart disease or diabetes?			
57. Is there a family history of sudden death at a young age?			
58. Are you ever aware of a racing or irregularly beating heart, or any other known problems with your heart beat?			
59. Have you ever had giddiness, light headedness of periods of unconsciousness whether or not associated with exercise?			
60. Do you ever get discomfort in your chest with exertion (angina)?			
61. Do you ever get very short of breath on exertion (out of proportion to the exercise, or before your legs get tired)?			
62. Have you ever been short of breath lying down or woken from sleep with breathlessness?			

CARDIOVASCULAR RISK QUESTIONS	YES	NO	Physician's comments
63. Do you have a pacemaker or implanted defibrillator?			
64. Have you ever had an operation on the heart including any placement of stents?			
65. Have you ever failed or had a significant medical issue with a diving medical in the past?			
66. Have you ever had a diagnosis of the following: • High blood pressure? • Rheumatic fever or problems with your heart valves? • High cholesterol? • Immersion pulmonary oedema? • Heart failure or a problem with heart muscle including cardiomyopathy or obstructive coronary heart disease? • A hole in the heart (PFO, ASD, VSD) or other congenital heart disease? • Blood clots on the lungs? • A stroke?	____ ____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____ ____	

Water skills and diving history

Previous Diving Experience? When, and how many dives?

Details: _____

_____

Previous qualifications (if any): _____

Can you swim? _____

Have you ever had any problem during or after swimming or diving?

Details: _____

Have you ever had decompression illness?

Details:_____

Do you snorkel dive regularly? _____

Candidate Statement

I certify that the above information is true and complete to the best of my knowledge. I hereby authorise (dive training organisation) _____ to pass this information to a diving doctor of my choosing. I also authorise that doctor to obtain or supply medical information regarding me to other doctors as may be necessary for medical purposes in my personal interest.

Signed: _____ **Date:** _____

Note
Any chronic disease, such as hepatitis A, B, C, AIDS or tuberculosis, may increase your risks from diving. If you have a chronic disease please discuss it with the doctor who will then be able to advise you whether you will be at increased risk.

SPUMS PRE-DIVE MEDICAL FORM FOR ENTRY-LEVEL SCUBA DIVERS

Append the diver medical statement above

Notes or additions to medical history: _____

_____

_____

MEDICAL EXAMINATION: To be completed by an Approved Medical Practitioner

1. Height cm	2. Weight kg	3.Visual acuity R 6/ Corrected 6/ L 6/ Corrected 6/	4. Blood Pressure mmHg	5. Pulse rate bpm
6. Urinalysis Albumin Glucose	7. Respiratory function tests including: (attach results) FVC FEV_1 Ratio (%)		8. CXR (if required) Date: Place: Result:	
9. Audiometry dB Right	(Hz) 500	1000 1500 2000 3000	4000 6000	8000
Left				
10. ECG (if indicated)				

Clinical Examination/Assessment	Normal	Abnormal	Notes on any abnormalities
11. Nose, septum, airway			
12. Mouth, throat, teeth, bite			
13. External auditory canal			
14. Tympanic membrane			
15. Middle ear autoinflation			
16. Neurological Eye movements Pupillary reflexes Limb reflexes Finger-nose Sharpened Romberg Test			
17. Abdomen			
18. Chest auscultation			
19. Cardiac auscultation			
20. Other abnormalities			

STATEMENT OF HEALTH FOR RECREATIONAL DIVING
This Section to be completed by a Medical Practitioner with appropriate training in diving medicine

This is to certify that I have today interviewed and examined:

Name.....

Address.....

.....

Date of birth...../...../.....

Initial the statements that apply:

	I have assessed the candidate in accordance with the SPUMS Recreational Dive Medical.
	I can find no conditions which are incompatible with compressed gas, scuba and surface supplied breathing apparatus (SSBA) and / or breath-hold diving.
	I have explained the health risks of diving disclosed by this examination to the candidate and we have discussed how these risks may be reduced. The candidate appears to have a good understanding of these risks.
	Based upon my assessment, the candidate should not dive with compressed gases (scuba and SSBA).
	Based upon my assessment, the candidate should not breath-hold dive.

Advice: (append further notes as required)

Condition 1: _____

Condition 2: _____

..../...../.....
(Signature of Medical Practitioner) (Date)
(Name, address and telephone number of the Medical Practitioner)

This Section to be completed by the Candidate
Initial the statements that apply:
..... I understand the health risks that I may encounter in diving and how these risks may be reduced.
..... I also understand that the medical practitioner's recommendation herewith is based, in part, upon the disclosure of my medical history.
..... I agree to accept any responsibility and liability for health risks associated with my participation in underwater diving, including those that are due to or are influenced by a change in my health and / or my failure to disclose any existing or past health condition to the medical practitioner.
..... I hereby authorise the medical practitioner to supply information with regard to my medical fitness to dive to the diving instructor.

..... ……..... ...../...../.....
Signature of candidate Name of Candidate Date