



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.

1	I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.	Yes Go to Box A	No <input checked="" type="checkbox"/>
2	I am over 45 years of age.	Yes Go to Box B	No <input checked="" type="checkbox"/>
3	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 <input checked="" type="checkbox"/>
4	I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes Go to Box C	No <input checked="" type="checkbox"/>
5	I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes *	No <input checked="" type="checkbox"/>
6	I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes Go to Box D	No <input checked="" type="checkbox"/>
7	I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability.	Yes Go to Box E	No <input checked="" type="checkbox"/>
8	I have had back problems, hernia, ulcers, or diabetes.	Yes Go to Box F	No <input checked="" type="checkbox"/>
9	I have had stomach or intestine problems, including recent diarrhea.	Yes Go to Box G	No <input checked="" type="checkbox"/>
10	I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes *	No <input checked="" type="checkbox"/>

Participant Signature

If you answered NO to all 10 questions above, 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.) Participant Name (Print) Chloe Kayll-Irvine



Instructor Name (Print)
Date (20/04/2022) Birthday (18/11/1999) Facility Name (NZ Dive School)

* 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

(Chloe Kayll-Irvine) Date (20/04/2022)

Diver Medical | Participant Questionnaire Continued

Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	Yes *	No
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes *	No
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
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes *	No
A diagnosis of COVID-19.	Yes *	No
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
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
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
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
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

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:

The Undersea & Hyperbaric Medical Society

DAN (US)

DAN Europe

Hyperbaric Medicine Division, University of California, San Diego