

Section: 3 (continued)	
9	Have you ever had any reactions to drugs, medicines or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If Yes - detail:</i>

Section: 4			
1	Next of kin name:	Relationship:	
2	Suburb:	State:	Postcode:
3	Home phone number: ()	Business phone number: ()	Mobile phone number:

Section: 5			Doctor's use only
Have you ever had, or do you now have or suffer from any of the following:			
1	Previous diving medical	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Prescription spectacles	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	Contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Eye or visual problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5	Dentures or plate	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Recent dental procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7	Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8	Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9	Nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10	Deafness or ringing noises in the ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11	Ear infections or discharge from the ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12	Giddiness or loss of balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13	Operation on the ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14	Other ear, nose or throat problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15	Severe motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16	Need to take seasickness medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17	Problems with ears or sinuses when flying in aircraft	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18	Severe or frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18	Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20	Fainting or blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21	Convulsions, fits or epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22	Unconsciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23	Head injury or concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24	Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25	Severe depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
28	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section: 5 (continued)				Doctor's use only
29	Abnormal blood test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
30	ECG	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
31	Palpitations or consciousness of your heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
32	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
33	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
34	Pain or discomfort in the chest on exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
35	Shortness of breath on exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
36	Bronchitis or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
37	Pleurisy or severe chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
38	Coughing up blood or phlegm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
39	Chronic or persistent cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
40	TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
41	Pneumothorax	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
42	Frequent chest colds or flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
43	Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
44	Need to use a puffer or inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
45	Operation on chest, lungs or heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
46	Other chest complaint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
47	Indigestion, acid reflux or peptic ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
48	Vomiting blood or passing red or black bowel motions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
49	Recurrent vomiting or diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
50	Jaundice, hepatitis or liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
51	Malaria or other tropical disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
52	Severe loss of weight	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
53	Hernia or rupture	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
54	Back injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
55	Significant joint problem or sports injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
56	Limitation of movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
57	Fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
58	Paralysis or muscle weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
59	Kidney or bladder diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
60	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
61	Sickle cell disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
62	Bleeding problem or other blood disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
63	Skin disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
64	Contagious disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
65	Operations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
66	List operations:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
67	Admitted to hospital	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
68	Rejected for life insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
69	Failed a medical examination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Section: 5 (continued)			<i>Doctor's use only</i>
70	Unable to work on medical grounds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
71	Any other illness or health problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
72	Family history of heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
73	Family history of asthma or chest disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Females only</i>			
74	Are you now pregnant or planning to be	<input type="checkbox"/> Yes <input type="checkbox"/> No	
75	Do you have periods which incapacitate you or which may reduce your physical or mental performance	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section: 6		<i>Doctor's use only</i>
Diving history to date		
1	Approx. date of first compressed air dive:	
2	Total hours under pressure:	
3	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	
4	How many dives to date:	
5	Longest dive:	
6	Deepest dive:	

Section: 7		<i>Doctor's use only</i>
Have you ever suffered from:		
1	Ear squeeze? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Sinus squeeze? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3	Decompression illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Headaches during or after dive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5	Extreme tiredness after dive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Any other diving related problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature:

Date: / /

AS/NZSS 2299 Medical Examination – Examination Findings

General comments:						

Section: A						
Visual acuity	Uncorrected	Corrected	Near vision	Colour Perception	Height	Weight
Right	6/	6/			cm	kg
Left	6/	6/			cm	kg
BP	/	Pulse	/min	Urinalysis		

Section: B			Notes & Comments
Head, Scalp, Face, Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
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 - Right	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Tympanic membrane - Left	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Eustachian tubes (ear clearing) - Right	<input type="checkbox"/> Easily with Valsalva		
	<input type="checkbox"/> With difficulty/alternate manoeuvres		
	<input type="checkbox"/> Nil/Unsatisfactory		
Eustachian tubes (ear clearing) - Left	<input type="checkbox"/> Easily with Valsalva		
	<input type="checkbox"/> With difficulty/alternate manoeuvres		
	<input type="checkbox"/> Nil/Unsatisfactory		
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	

Section: B (continued)					Notes & Comments	
Peripheral pulses	<input type="checkbox"/> Right Dorsalls Pedis <input type="checkbox"/> Left Dorsalls Pedis <input type="checkbox"/> Right Post Tibial <input type="checkbox"/> Left Post Tibial					
Tendon reflexes	Absent	Weak	Mid-range	Brisk		Hyperreflexic
Biceps Right	_____					
Biceps Left	_____					
Triceps Right	_____					
Triceps Left	_____					
B/Rad Right	_____					
B/Rad Left	_____					
Knee Right	_____					
Knee Left	_____					
Ankle Right	_____					
Ankle Left	_____					
<i>(mark line to indicate strength of reflex elicited)</i>						
Sensation	<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal			
Cerebellar functions	<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal			
Sharpened Romberg test Time stable (s)	<input type="checkbox"/> Very stable <input type="checkbox"/> Major swaying/wobbles <input type="checkbox"/> A few minor sways/wobbles <input type="checkbox"/> Unable to hold balance					
No. of attempts	<input type="checkbox"/> Moderately unsteady					
Emotional & psychiatric stability	<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal			
Exercise tolerance	<input type="checkbox"/> Fitness good – History <input type="checkbox"/> Fitness acceptable – History <input type="checkbox"/> Exercise test requested <input type="checkbox"/> Exercise test performed (specify type & result)					
CXR	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending			
Lung function	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending			
Audiometry	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending			
Tympanometry	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending			
Long Bone Survey	<input type="checkbox"/> Not indicated		<input type="checkbox"/> Recommended			
Other tests	<input type="checkbox"/> Nil required					
	<input type="checkbox"/> Indicated (specify)					
Other abnormalities	<input type="checkbox"/> Nil noted					
	<input type="checkbox"/> Noted (specify)					

