



# Milton Clinic – Dr Osborne & Dr Woodhead

Level 1, Centro Milton,  
36 Baroona Road,  
Milton, QLD 4064  
Tel: (07) 3369 5133

## Medical Questionnaire

### AS 4005.1 (REC) Diving Medical Examination

Please complete the following: (check boxes mark with ☒)

Section: 1			
1	Surname:	Given names:	
2	Date of birth:     /     /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
3	Address:		
4	Suburb:	State:	Postcode:
5	Home phone number: (    )	Business phone number: (    )	Mobile phone number:
6	Occupation:		

Section: 2			Details
1	Do you participate in regular physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Description of activity:		
3	Do you smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	How many cigarettes do you smoke per day?		
5	Have you been a smoker in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7	How many drinks per week (average)?		
8	Do you take any tablets, medicines or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9	List medications taken:		
10	1)	3)	
11	2)	4)	
12	Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13	Have you ever had any reactions to drugs, medicines or foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section: 3			Notes on history
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	Denture/plates, dental prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Recent dental procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Section: 3 (continued)</b>				<i>Notes on history</i>
7	Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8	Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9	Any other nose or throat problem	<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	Severe motion sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
15	Need to take seasickness medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16	Any problems when flying in aircraft	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
17	Severe or frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
18	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
19	Fainting or blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
20	Convulsions, fits or epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
21	Unconsciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
22	Head injury or concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
23	Sleepwalking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
24	Severe depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
25	Claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
26	Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
27	Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
28	Abnormal blood test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
29	ECG (heart tracing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
30	Palpitations or consciousness of your heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
31	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
32	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
33	Pain or discomfort in the chest on exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
34	Shortness of breath on exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
35	Bronchitis or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
36	Pleurisy or severe chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
37	Coughing up blood or phlegm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
38	Chronic or persistent cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
39	TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
40	Pneumothorax (collapsed lung)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
41	Frequent chest colds or flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
42	Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
43	Need to use a puffer or inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
44	Operation on chest, lungs or heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
45	Other chest complaint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
46	Indigestion, acid reflux or peptic ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
47	Vomiting blood or passing red or black bowel motions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Section: 3 (continued)</b>			<i>Notes on history</i>	
48	Recurrent vomiting or diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No		
49	Jaundice, hepatitis or liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
50	Malaria or other tropical disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
51	Severe loss of weight	<input type="checkbox"/> Yes <input type="checkbox"/> No		
52	Hernia or rupture	<input type="checkbox"/> Yes <input type="checkbox"/> No		
53	Back injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		
54	Significant joint problem or sports injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		
55	Limitation of movement	<input type="checkbox"/> Yes <input type="checkbox"/> No		
56	Fracture (broken bones)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
57	Paralysis or muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
58	Kidney or bladder diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No		
59	In a high risk group for AIDS or HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No		
60	Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
61	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
62	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
63	Bleeding problem or other blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
64	Skin disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
65	Contagious disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
67	Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
68	Admitted to hospital for any reason	<input type="checkbox"/> Yes <input type="checkbox"/> No		
69	Rejected for life insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
70	A job or a licence refused on medical grounds	<input type="checkbox"/> Yes <input type="checkbox"/> No		
71	Unable to work on medical grounds	<input type="checkbox"/> Yes <input type="checkbox"/> No		
72	An invalid pension	<input type="checkbox"/> Yes <input type="checkbox"/> No		
73	Any other illness or health problem	<input type="checkbox"/> Yes <input type="checkbox"/> No		
74	Family history of heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
75	Family history of asthma or chest disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
76	Family history of tuberculosis or TB	<input type="checkbox"/> Yes <input type="checkbox"/> No		
77	Date of last chest x ray	/ /		
<i>Females only</i>				
78	Are you now pregnant or planning to be	<input type="checkbox"/> Yes <input type="checkbox"/> No		
79	Do you have periods which incapacitate you or which may reduce your physical or mental performance	<input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Section: 4</b>			<i>Notes</i>
Previous diving experience			
1	Can you swim?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2	Have you ever had any problems during or after swimming or diving?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	Have you ever had to be rescued?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Do you snorkel or dive regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section: 4 (continued)		Notes
5	Have you tried SCUBA diving before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Have you ever had formal scuba training? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7	Year:	
8	Approximate number of dives:	
9	Maximum depth or any dive:	
10	Longest duration of any dive:	

I certify that this information is true and complete to the best of my knowledge and I hereby authorise Dr \_\_\_\_\_ to give medical opinion as to my fitness or temporary or permanent unfitness to dive to my diving instructor. I also authorise him or her to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signature: .....

Date: / /

To Be Completed By A Registered Medical Practitioner:				Notes			
1	Height:						
2	Weight:						
3	Vision:	Right Uncorrected 6/					
		Left Uncorrected 6/					
		Right Corrected 6/					
		Left Corrected 6/					
4	Blood pressure:	/					
5	Pulse:	/min					
6	Urinalysis:	Albumin: Neg / Pos	Glucose: Neg / Pos				
7	PFT:	FEV1					
		FVC					
		%					
8	Chest x ray (if indicated):	Date: / /					
		Place:					
		Result:					
9	Audiometry (air conduction)						
	Frequency	500	1000	2000	4000	6000	8000
	Loss in dB - Right						
	Loss in dB - Left						

*If abnormal enter on certificate, in logbook or both.*

Clinical Assessment:				Notes
10	Nose,septum,airway	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
11	Mouth, throat, teeth, bite	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
12	External auditory canal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
13	Tympanic membrane	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
14	Middle ear auto inflation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
15	Neurological eye movements	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
16	Neurological Pupillary reflexes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
17	Neurological limb reflexes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
18	Neurological – Finger- Nose	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
19	Neurological Sharpened Romberg*	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
20	Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
21	Chest hyperventilation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
22	Cardiac auscultation	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
23	Other abnormalities	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	

\* Results should be descriptively detailed at right to assist future comparison

General Comments:

Examination Summary:		
Fitness to dive certification:	<input type="checkbox"/> Yes	Special Advice:
	<input type="checkbox"/> No	Temporary Reason:
	<input type="checkbox"/> No	Permanent Reason:

**Medical Officer:**

Dr Cameron Osborne .....

Date: / /

or

Dr Keith Woodhead .....

Date: / /