

## 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 and/or blood affecting my normal physical or mental performance.                                                                                                                                                      | Yes <input type="checkbox"/><br>Go to box <b>A</b> | No <input type="checkbox"/> |
| 2  | I am over 45 years of age.                                                                                                                                                                                                                                                | Yes <input type="checkbox"/><br>Go to box <b>B</b> | No <input 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 <input type="checkbox"/> *                     | No <input type="checkbox"/> |
| 4  | I have had problems with my eyes, ears, or nasal passages/sinuses.                                                                                                                                                                                                        | Yes <input type="checkbox"/><br>Go to box <b>C</b> | No <input type="checkbox"/> |
| 5  | I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.                                                                                                                                                                         | Yes <input type="checkbox"/> *                     | No <input type="checkbox"/> |
| 6  | I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.                                                                                                                     | Yes <input type="checkbox"/><br>Go to box <b>D</b> | No <input 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 or developmental disability.  | Yes <input type="checkbox"/><br>Go to box <b>E</b> | No <input type="checkbox"/> |
| 8  | I have had back problems, hernia, ulcers, or diabetes.                                                                                                                                                                                                                    | Yes <input type="checkbox"/><br>Go to box <b>F</b> | No <input type="checkbox"/> |
| 9  | I have had stomach or intestine problems, including recent diarrhea.                                                                                                                                                                                                      | Yes <input type="checkbox"/><br>Go to box <b>G</b> | No <input type="checkbox"/> |
| 10 | I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam).                                                                                                                                       | Yes <input type="checkbox"/> *                     | No <input 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.)

Date (dd/mm/yyyy)

Participant Name (Print)

Birthdate (dd/mm/yyyy)

Instructor Name (Print)

Facility Name (Print)

**\* 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.

## Diver Medical | Participant Questionnaire Continued

|                                                                                                                                                                                                                                             |                                |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------|
| <b>BOX A – I HAVE/HAVE HAD:</b>                                                                                                                                                                                                             |                                |                             |
| Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.                                                                        | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.                                                                                                     | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.                                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX B – I AM OVER 45 YEARS OF AGE AND:</b>                                                                                                                                                                                               |                                |                             |
| I currently smoke or inhale nicotine by other means.                                                                                                                                                                                        | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| I have a high cholesterol level.                                                                                                                                                                                                            | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| I have high blood pressure.                                                                                                                                                                                                                 | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX C – I HAVE/HAVE HAD:</b>                                                                                                                                                                                                             |                                |                             |
| Sinus surgery within the last 6 months.                                                                                                                                                                                                     | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Ear disease or ear surgery, hearing loss, or problems with balance.                                                                                                                                                                         | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurrent sinusitis within the past 12 months.                                                                                                                                                                                              | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Eye surgery within the past 3 months.                                                                                                                                                                                                       | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX D – I HAVE/HAVE HAD:</b>                                                                                                                                                                                                             |                                |                             |
| Head injury with loss of consciousness within the past 5 years.                                                                                                                                                                             | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Persistent neurologic injury or disease.                                                                                                                                                                                                    | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Recurring migraine headaches within the past 12 months, or take medications to prevent them.                                                                                                                                                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.                                                                                                                                                         | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Epilepsy, seizures, or convulsions, OR take medications to prevent them.                                                                                                                                                                    | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX E – I HAVE/HAVE HAD:</b>                                                                                                                                                                                                             |                                |                             |
| Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.                                                                                                                                                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.                                                                                                     | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| An addiction to drugs or alcohol requiring treatment within the last 5 years.                                                                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX F – I HAVE/HAVE HAD:</b>                                                                                                                                                                                                             |                                |                             |
| Recurrent back problems in the last 6 months that limit my everyday activity.                                                                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Back or spinal surgery within the last 12 months.                                                                                                                                                                                           | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.                                                                                                                                                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| An uncorrected hernia that limits my physical abilities.                                                                                                                                                                                    | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.                                                                                                                                                      | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| <b>BOX G – I HAVE HAD:</b>                                                                                                                                                                                                                  |                                |                             |
| Ostomy surgery and do not have medical clearance to swim or engage in physical activity.                                                                                                                                                    | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Dehydration requiring medical intervention within the last 7 days.                                                                                                                                                                          | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.                                                                                                                                                 | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).                                                                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Active or uncontrolled ulcerative colitis or Crohn's disease.                                                                                                                                                                               | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |
| Bariatric surgery within the last 12 months.                                                                                                                                                                                                | Yes <input type="checkbox"/> * | No <input type="checkbox"/> |

# Diver Medical | Medical Examiner's Evaluation Form

|                  |                   |
|------------------|-------------------|
| Participant Name | Birthdate         |
| <hr/>            | <hr/>             |
| (Print)          | Date (dd/mm/yyyy) |

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit [uhms.org](https://uhms.org) for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

## Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

|                                                                                   |                   |
|-----------------------------------------------------------------------------------|-------------------|
| <hr/>                                                                             | <hr/>             |
| Signature of certified medical doctor or other legally certified medical provider | Date (dd/mm/yyyy) |

Medical Examiner's Name

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(Print)

Clinical Degrees/Credentials

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Clinic/Hospital

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Address

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|       |       |
|-------|-------|
| Phone | Email |
| <hr/> | <hr/> |

Physician/Clinic Stamp (optional)

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**