

# MICRODIVE

## TRAINING PROGRAMME

### PERSONAL MEDICAL QUESTIONNAIRE

Scuba diving activities can place unusual and unexpected physical demands on the participant so it is important to ensure that you are fit to dive before engaging in any form of underwater activity.

This medical questionnaire establishes if you have any pre-existing conditions that could affect your safety while diving so it is important that you answer the questions accurately by marking against each with either a YES or a NO.

If you are not sure if a condition mentioned applies to you, you must answer YES in which case you must seek professional medical advice from your physician before participating in underwater activities.

#### QUESTION – Do you currently or have you ever suffered from the following conditions: Y or N

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Epilepsy or seizures of any kind?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma, wheezing or breath restriction of any kind?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pneumothorax (A condition where the lung has collapsed)?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung disease of any kind?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernias, ulcers or colostomy?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Colds, sinusitis, bronchitis?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hay fever or other allergies?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart attacks?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest surgery?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding or severe blood disorders?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Claustrophobia?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Agoraphobia?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches, migraine attacks?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blackouts?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back problems and or surgery?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sinus or ear surgery?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing loss or problems with balance?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty equalising ears in an airplane or on high ground? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug or alcohol abuse?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Motion sickness?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decompression sickness or related diving accidents?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Registered behavioural health problems?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty in conducting physical exercise?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

#### SPECIAL CONSIDERATIONS

- Are you or could you be pregnant?  Yes  No
- Are you 45 years or over, do you smoke, have a high cholesterol level or a family history of heart problems?  Yes  No

#### DECLARATION

I declare that the answers I have given to the above questions are true and accurate to the best of my knowledge.

STUDENTS NAME (PRINT) \_\_\_\_\_

DATE \_\_\_\_\_

STUDENTS NAME (SIGNATURE) \_\_\_\_\_

DATE \_\_\_\_\_

PARENT/GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_