Participant Name (Print) **Birthdate** Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

Box A – I have/have had:		
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 ☐

Box B – I am over 45 years of age AND:		
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 ☐

Box C – I have/have had:		
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 ☐

Box D – I have/have had:		
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 ☐

Box E – I have/have had:		
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 ☐

Box F – I have/have had:		
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 ☐
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes * ☐	No ☐
An uncorrected hernia that limits my physical abilities.	Yes * ☐	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes * ☐	No ☐

Box G – I have had:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes * ☐	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes * ☐	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes * ☐	No ☐
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes * ☐	No ☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes * ☐	No ☐
Bariatric surgery within the last 12 months.	Yes * ☐	No ☐

* Physician's medical evaluation required (see page 1).

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Participant Name ______________________ **Birthdate** ______________________

(Print) Date (dd/mm/yyyy)

Diver Medical | Physician's Evaluation Form

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 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.

______________________ ______________________

Physican's Signature Date (dd/mm/yyyy)

Physician's Name ______________________ **Specialty** ______________________

(Print)

Clinic/Hospital ______________________

Address ______________________

Phone ______________________ **Email** ______________________

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