

Medical Questionnaire

This questionnaire is provided by **Aliwal Dive Centre**. Contact us on:

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Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When established safety procedures are not followed, however, there are increased risks.

To scuba dive safely, you should not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with coronary disease, a current cold or congestion, epilepsy, a severe medical problem or who is under the influence of alcohol or drugs should not dive. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in any diving programme and on a regular basis thereafter completion. You will also learn from the instructor the important safety rules regarding breathing and equalization while scuba diving.

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer YES. If any of these items apply to you, we must request that you consult with a physician prior to participating in scuba diving. We will supply you with a RSTC Medical Statement and Guidelines for Recreational Scuba Divers Physical Examination to take to your physician.

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|--|------------------------------|-----------------------------|
| 1. Could you be pregnant, or are you attempting to become pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Are you currently taking prescription medication? (with the exception of birth control or anti-malarial) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Are you over 45 years of age and can say YES to any one or more of the following: | | |
| Currently smoke a pipe, cigars or cigarettes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have a high cholesterol level | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have a family history of heart attack or stroke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are currently receiving medical care | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| High blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes mellitus, even if controlled by diet alone | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Have you ever had, or do you currently have: | | |
| Asthma, or wheezing with breathing or wheezing with exercise? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent or severe attacks of hayfever or allergy? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent colds, sinusitis or bronchitis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any form of lung disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Pneumothorax (collapsed lung)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Other chest disease or chest surgery? | | |
| Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy, seizures, convulsions or take medicine to prevent them? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurring complicated migraine headaches or take medicine to prevent them? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blackouts or fainting (full/partial loss of consciousness)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent or severe suffering from motion sickness (seasick, carsick, etc)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dysentery or dehydration requiring medical intervention? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any dive accidents or decompression sickness? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Inability to perform moderate exercise (eg. Walk 1.6km/one mile within 12 minutes)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Head injury with loss of consciousness in the past 5 years? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent back problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Back or spinal surgery? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Back, arm or leg problems following surgery, injury or fracture? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| High blood pressure or take medicine to control blood pressure? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart attack? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Angina, heart surgery or blood vessel surgery? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinus surgery? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ear disease or surgery, hearing loss or problems with balance? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent ear problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding or other blood disorders? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hernia? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ulcers or ulcer surgery? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| A colostomy or ileostomy? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recreational drug use or treatment for, or alcoholism in the past 5 years? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please complete and fax or email back to Aliwal Dive Centre