Please read carefully before signing.

1. Surname _____ Other Names _____

2. Date of Birth (dd/mm/yyyy) _____

3. Address _____

_____

State: _____ Postcode _____

4. Sex Male / Female

5. Telephone (Home) _____

6. Principal Occupation _____

7. Telephone (Work) _____

8. Email (Optional) _____

9. Are you regularly taking any prescription tablets, medicines or drugs?

List: _____

_____

10. Have you had any reactions to drugs or medicines or foods?

Details: _____

_____

Please answer the following questions on your past or present medical history (from question 11 onwards) with a YES or NO. If you are not sure, answer YES.

Have you ever had or do you now have any of the following? Tick Yes or No

	YES	NO	Physician's comments
11. Any continuing eye or visual problems (apart from needing glasses or contact lenses)?			
12. Sinusitis (e.g. hay fever, sinus infections)?			
13. Any other nose or throat problem (apart from previous coughs and colds)?			
14. Dentures or plates that are removable?			
15. Deafness or ringing noises in ear(s)?			

	YES	NO	Physician's comments
16. Discharging ears or other infections?			
17. Previous ear operation (including as a child)?			
18. Giddiness or loss of balance?			
19. Severe motion sickness?			
20. Any ear problems or severe headaches when flying in aircraft?			
21. Severe or frequent headaches, including migraine?			
22. Faints or blackouts?			
23. Convulsions, fits or epilepsy?			
24. Any episodes of unconsciousness?			
25. Depression requiring medical treatment?			
26. Claustrophobia?			
27. Mental illness?			
28. Heart disease?			
29. Awareness of a racing or irregular heart beat?			
30. High blood pressure?			
31. Rheumatic fever?			
32. Discomfort in your chest with exertion?			
33. Very short of breath on exertion (out of proportion to the exercise)?			
34. Bronchitis or pneumonia?			
35. Pleurisy or severe chest pain?			
36. Coughing up phlegm or blood?			
37. Chronic or persistent cough?			
38. Tuberculosis ("TB")?			
39. Pneumothorax ("collapsed lung")?			
40. Frequent chest colds?			
41. Asthma or wheezing?			
42. Use a puffer (medication inhaler for asthma)?			
43. Any other chest complaint?			
44. Operation on chest, lungs, or heart?			
45. Peptic ulcer or acid reflux requiring treatment?			
46. Vomiting blood or passing red or black motions?			
47. Jaundice, hepatitis or liver disease?			
48. Malaria?			

49. Severe loss of weight?			
50. Hernia or rupture?			
51. Major joint or back injury?			
52. Paralysis, muscle weakness or numbness?			
53. Kidney disease?			
54. Diabetes?			
55. Blood disease or bleeding problem?			
56. Could you be pregnant, or are you trying to become pregnant?			
57. Have you ever had a diving accident or decompression illness/sickness?			

Water skills

Previous Diving Experience? When, and how many dives?

Details: _____

Previous qualifications (if any): _____

Can you swim? _____

Have you ever had any problem during or after swimming or diving?

Details: _____

Do you snorkel dive regularly? _____

Candidate Statement

I certify that the above information is true and complete to the best of my knowledge. I hereby authorise (dive training organisation) _____ to pass this information to a diving doctor of my choosing. I also authorise that doctor to obtain or supply medical information regarding me to other doctors as may be necessary for medical purposes in my personal interest.

Signed: _____ **Date:** _____

Note
Any chronic disease, such as hepatitis A, B, C, AIDS or tuberculosis, may increase your risks from diving. If you have a chronic disease please discuss it with the doctor who will then be able to advise you whether you will be at increased risk.