coralexpeditions
AUSTRALIA'S PIONEERING CRUISE LINE

MEDICAL RISK ASSESSMENT FOR RECREATIONAL DIVING

SECTION ONE			
1.	**SURNAME:**		**GIVEN NAME:**
2.	**DATE OF BIRTH:** __/__/____		**SEX:** Male / Female
3.	**ADDRESS:**		
4.	**SUBURB:**	**STATE:**	**POSTCODE:**
5.	**HOME PHONE:** (__)	**MOBILE:** (__)	**EMAIL:**
6.	**OCCUPATION:**		

SECTION TWO			DETAILS
1.	Do you participate in regular physical activity?	Yes / No	
2.	Description of activity & Minutes per week:		
3.	Do you smoke cigarettes?	Yes / No	
4.	How many cigarettes do you smoke per day?		
5.	Have you been a smoker in the past?	Yes / No	
6.	Do you drink alcohol?	Yes / No	
7.	How many drinks per week (average)?		
8.	Do you take any tablets, medicines or drugs?	Yes / No	
9.	List medications taken: 1) 2) 3) 4)		
10.	Do you have any allergies?	Yes / No	
11.	Have you ever had any reactions to drugs, medicines or foods?	Yes / No	

SECTION THREE			NOTES ON HISTORY
1.	Previous diving medical	Yes / No	
2.	Prescription spectacle	Yes / No	
3.	Contact lenses	Yes / No	
4.	Eye or visual problem	Yes / No	
5.	Denture/ Plates/ Dental prosthesis	Yes / No	
6.	Recent dental procedure	Yes / No	
7	Hay Fever	Yes / No	
8.	Sinusitis	Yes / No	

SECTION THREE			NOTES ON HISTORY
9.	Any other nose or throat problem	Yes / No	
10.	Deafness or ringing noises in the ear	Yes / No	
11.	Ear infections or discharge from the ear	Yes / No	
12.	Giddiness or loss of balance	Yes / No	
13.	Operation on the ear	Yes / No	
14.	Severe motion sickness	Yes / No	
15.	Need to take seasickness medication	Yes / No	
16.	Any problems when flying in aircraft	Yes / No	
17.	Severe or frequent headaches	Yes / No	
18.	Migraine	Yes / No	
19.	Fainting or blackouts	Yes / No	
20.	Convulsions, fits or epilepsy	Yes / No	
21.	Unconsciousness	Yes / No	
22.	Head injury or concussion	Yes / No	
23.	Sleepwalking	Yes / No	
24.	Severe depression	Yes / No	
25.	Claustrophobia	Yes / No	
26.	Mental Illness	Yes / No	
27.	Heart disease	Yes / No	
28.	Abnormal blood test	Yes / No	
29.	ECG (heart tracing)	Yes / No	
30.	Palpitations or consciousness of your heartbeat	Yes / No	
31.	High blood pressure	Yes / No	
32.	Rheumatic fever	Yes / No	
33.	Pain or discomfort in the chest on exertion	Yes / No	
34.	Shortness of breath on exertion	Yes / No	
35.	Bronchitis or pheumonia	Yes / No	
36.	Pleurisy or severe chest pain	Yes / No	
37.	Coughing up blood or phlegm	Yes / No	
38.	Chronic or persistent cough	Yes / No	
39.	Tuberculosis (TB)	Yes / No	
40.	Pneumothorax (collapsed lung)	Yes / No	
41.	Frequent chest colds or flue	Yes / No	
42.	Asthma or wheezing	Yes / No	
43.	Need to use a puffer or inhaler	Yes / No	

SECTION THREE CONTINUED			NOTES ON HISTORY CONTINUED
44.	Operation on chest, lungs or heart	Yes / No	
45.	Other chest complaint	Yes / No	
46.	Indigestion, acid reflux or peptic ulcer	Yes / No	
47.	Vomiting blood or passing red or black bowel motions	Yes / No	
48.	Recurrent vomiting or diarrhoea	Yes / No	
49.	Jaundice, hepatitis or liver disease	Yes / No	
50.	Malaria or other tropical disease	Yes / No	
51.	Severe loss of weight	Yes / No	
52.	Hernia or rupture	Yes / No	
53.	Back injury	Yes / No	
54.	Significant joint problem or sports injury	Yes / No	
55.	Limitation of movement	Yes / No	
56.	Fracture (broken bones)	Yes / No	
57.	Paralysis or muscle weakness	Yes / No	
58.	Kidney or bladder diseases	Yes / No	
59.	In a high risk group for AIDS or HIV	Yes / No	
60.	Syphilis	Yes / No	
61.	Diabetes	Yes / No	
62.	Sickle cell disease	Yes / No	
63.	Bleeding problem or other blood disease	Yes / No	
64.	Skin disease	Yes / No	
65.	Contagious disease	Yes / No	
66.	Operations	Yes / No	
67.	Admitted to hospital for any reason	Yes / No	
68.	Rejected for life insurance	Yes / No	
69.	A job or a licence refused on medical grounds	Yes / No	
70.	Unable to work on medical grounds	Yes / No	
71.	An invalid pension	Yes / No	
72.	Any other illness or health problem	Yes / No	
73.	Family History of heart disease	Yes / No	
74.	Family history of asthma or chest disease	Yes / No	
75.	Family history of tuberculosis (TB)	Yes / No	
76.	Date of last chest Xray	Yes / No	
77.	**Females Only:** Are you now pregnant or planning to be?	Yes / No	
78.	**Females Only:** Do you have periods which incapacitate you or which may reduce your physical or mental performance?	Yes / No	

SECTION FOUR - PREVIOUS DIVING EXPERIENCE			NOTES
1.	Can you swim?	Yes / No	
2.	Have you ever had any problems during or after swimming or diving? (including decompression illness)	Yes / No	
3.	Have you ever had to be rescured?	Yes / No	
4.	Do you snorkel or dive regularly?	Yes / No	
5.	Have you tried SCUBA diving before?	Yes / No	
6.	Have you ever had formal scuba training?	Yes / No	
	Year:		
7.	Approximate number of dives:		
8.	Maximum depth of any dive:		
9.	Longest duration of any dive:		

I certify that this information is true and complete to the best of my knowledge and I hereby authorise Dr _____ to give medical opinion as to my fitness or temporary or permanent unfitness to dive to my diving instructor. I also authorise him or her to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signature: _____ 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 dicuss this with your doctor prior to diving, so they can advise you whether you will be at increased risk.

TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER				NOTES
1.	Height			
2.	Weight			
3.	Vision	Right Uncorrected: 6/		
		Left Uncorrected: 6/		
		Right Corrected: 6/		
		Right Corrected: 6/		
4.	Blood Pressure	/		
5.	Pulse	/ Minute		
6.	Urinalysis	Albumin: Negative / Positive		
		Glucose: Negative / Positive		
7.	PFT	FEV1		
		FVC		
		%		
8.	Chest X-Ray (if indicated)	Date: / /		
		Place:		
		Result:		
9.	Nose/ Septum/ Airway	Normal	Abnormal	
10.	Mouth/ Throat/ Teeth/ Bite	Normal	Abnormal	
11.	External auditory capacity	Normal	Abnormal	
12.	Tympanic membrane	Normal	Abnormal	
13.	Middle ear auto inflation	Normal	Abnormal	
14.	Neurological eye movements	Normal	Abnormal	
15.	Neurological Pupillary reflexes	Normal	Abnormal	
16.	Neurological limb reflexes	Normal	Abnormal	
17.	Neurological - Finger-Nose	Normal	Abnormal	
18.	Neurological Sharpened Romberg*	Normal	Abnormal	
19.	Abdomen	Normal	Abnormal	
20.	Chest Hyperventilation	Normal	Abnormal	
21.	Cardiac Auscultation	Normal	Abnormal	
22.	Other abnormalities	Normal	Abnormal	

**Results should be descriptively detailed at right to assist future comparison*

GENERAL COMMENTS

EXAMINATION SUMMARY			
Fitness to dive certification	YES	Special Advice:	
	NO	Temporary Reason:	
	NO	Permanent Reason:	

MEDICAL OFFICER

Print Name: Signature:

_____ _____ Date / /

_____ _____ Date / /