Form 1 (1110) - AUSI MEDICAL HISTORY FORM

This form is used for the assessment of potential problems for persons wishing to partake in AUSI Snorkel or AUSI Scuba programs. In the interest of your safety it is important that you give true, full and complete answers to all questions. Your instructor may advise you to have a full diving medical before diving or may recommend that you do not dive at all.

IMPORTANT: Do you understand that incorrect or misleading information can lead to serious injury resulting in permanent damage or death? YES ☐ NO ☐

A. PERSONAL DETAILS

Name _____ Date of Birth ___/___/___

Address _____

Contact Email: _____ Mobile: _____ Phone: _____

Sex : Male ☐ Female ☐ Occupation _____

Where did you hear about this course? _____

B. GENERAL INFORMATION

	YES	NO	
1. Can you swim 200m (220 yds)?	☐	☐	
2. Have you ever had trouble in water?	☐	☐	Details _____
3. Have you scuba dived previously?	☐	☐	Details _____
4. Are you in good health?	☐	☐	Details _____
5. Are you on any medication?	☐	☐	Details _____
6. Operations within the last six months?	☐	☐	Details _____
7. Is there a family history of heart disease?	☐	☐	Details _____
8. Do you have any disease or disability?	☐	☐	Details _____
9. Do you smoke?	☐	☐	Pack Years (Should be < 10)

Cigarettes per day ☐ Multiply by years of smoking ☐ Divide by 20 = ☐

	YES	NO
10. Have you consumed alcohol or any other drugs within the last 24 hours?	☐	☐
11. Will you be flying or going to altitudes above 300m within 24 hours after your last scuba dive?	☐	☐

Do you suffer from, or have you ever suffered any of the following?

12. Ear problems when flying or diving	☐	☐	17. Migraine or severe headache	☐	☐
13. Ruptured eardrum	☐	☐	18. Depression or claustrophobia	☐	☐
14. Chronic ear discharge or infection	☐	☐	19. Anxiety or panic attacks	☐	☐
15. Sea sickness	☐	☐	20. Recompression for a diving related illness	☐	☐
16. Back problems	☐	☐	21. Have you ever used a Puffer	☐	☐

C. MEDICAL HISTORY - Do you suffer from, or have you ever suffered any of the following?

	YES	NO		YES	NO
1. Ear surgery (other than drainage)	☐	☐	11. Pneumothorax (collapsed lung)	☐	☐
2. Persistent ringing noises or deafness	☐	☐	12. Persistent fainting or blackouts	☐	☐
3. Persistent loss of balance	☐	☐	13. Head injury requiring hospitalisation	☐	☐
4. Persistent allergies affecting nose/sinuses	☐	☐	14. Epilepsy or fits	☐	☐
5. Persistent cough or coughing blood	☐	☐	15. Any brain or spinal disorder	☐	☐
6. Recurrent chest/lung infections/problems	☐	☐	16. Diabetes	☐	☐
7. Abnormal chest pain	☐	☐	17. Heart disease	☐	☐
8. Chest surgery (heart or lung)	☐	☐	18. High blood pressure	☐	☐
9. Abnormal shortness of breath	☐	☐	19. Pulse irregularities	☐	☐
10. Asthma or wheezing	☐	☐	20. Are you pregnant or trying to be pregnant?	☐	☐

D. DECLARATION

I certify that the above information is true and complete to the best of my knowledge and I hereby authorize Dr _____ Phone # _____ to supply medical information relevant to this course regarding me to my instructor in my own personal interest.

Student's signature _____ Date ___/___/___

Instructor's signature _____ Instructor #: _____