

# AS/NZS 2299.1 Supplement 1:2015

## Occupational diving operations

### Part 1: Standard operational practice Supplement 1: AS/NZS 2299 diving medical examination forms (Supplement to AS/NZS 2299.1:2015)



## PREFACE

This Supplement was prepared by the Joint Standards Australia/Standards New Zealand Committee SF-017, Occupational Diving, to supersede AS/NZS 2299.1 Supp 1:2007, *Occupational diving operations, Part 1: Standard operational practice*, Supplement 1: *AS/NZS 2299 diving medical examination forms (Supplement to AS/NZS 2299.1:2007)*.

This Supplement is a copy of material from Appendix L of AS/NZS 2299.1:2015. For requirements relating to the application of these forms, refer to AS/NZS 2299.1:2015

**AS/NZS 2299.1 Occupational Diving Medical Examination—Medical Questionnaire**

*Please complete the following:*

Surname	Given names		
Address			
Date of birth	Sex	M	F
Phone (home)	Phone (work)	Phone (mobile)	
Occupation			
Most recent dive medical date			
Name of Diver's General Practitioner			
Type of Medical			
Unrestricted—including saturation		Limited Occupational Diving—specify type.....	
Unrestricted—not including saturation		Recreational Diving Industry work only	
Do you participate in any regular physical activity: Type of physical activity:			
Rarely	<1/week	Weekly	2–3/week Most days
How many cigarettes do you smoke per day?		Have you been a smoker in the past? Yes No	
Do you drink alcohol?		Yes No	How many drinks per week (average)?
Do you take any tablets, medicines or drugs? List:		Yes No	
In the past 12 months, have you consumed or smoked any illicit drugs?		Yes No	
Do you have any allergies? List:		Yes No	
Have you ever had any reactions to drugs, medicines or foods? List:		Yes No	
Next of kin name		Relationship	
Address			
Phone number(s)			
Diving history to date			<b>Doctor's use only</b>
Approx. date of first compressed air dive.....			
Total hours under pressure .....			
Types of diving experience:			
<input type="checkbox"/> Scuba air	<input type="checkbox"/> Surface supply	<input type="checkbox"/> Saturation	
<input type="checkbox"/> Scuba mix gas	<input type="checkbox"/> Surface deco	<input type="checkbox"/> Oxygen	
<input type="checkbox"/> Hookah	<input type="checkbox"/> Bell diving		
How many dives to date .....			
Longest dive .....			
Deepest dive .....			
Have you ever suffered from—			
ear squeeze? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
sinus squeeze? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
decompression illness? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
headaches during or after dive? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
extreme tiredness after dive? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any other diving-related problems? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, specify .....			

Candidate's name .....

**Have you ever had, or do you now have or suffer from, any of the following?**

**Doctor's use only**

- Prescription spectacles .....  Yes  No
- Contact lenses.....  Yes  No
- Eye or visual problem .....  Yes  No
- Dentures or plate .....  Yes  No
- Recent dental procedure .....  Yes  No
- Hay fever.....  Yes  No
- Sinusitis.....  Yes  No
- Nosebleeds .....  Yes  No
- Deafness or ringing noises in the ear .....  Yes  No
- Ear infections or discharge from the ear .....  Yes  No
- Giddiness or loss of balance .....  Yes  No
- Operation on the ear.....  Yes  No
- Other ear, nose or throat problem .....  Yes  No
- Severe motion sickness .....  Yes  No
- Need to take seasickness medication .....  Yes  No
- Problems with ears or sinuses when flying in aircraft .....  Yes  No
- Severe or frequent headaches .....  Yes  No
- Migraine .....  Yes  No
- Fainting or blackouts.....  Yes  No
- Convulsions, fits or epilepsy.....  Yes  No
- Unconsciousness.....  Yes  No
- Head injury or concussion .....  Yes  No
- Sleepwalking .....  Yes  No
- Severe depression.....  Yes  No
- Claustrophobia .....  Yes  No
- Mental illness .....  Yes  No
- Heart disease .....  Yes  No
- Abnormal blood test.....  Yes  No
- ECG .....  Yes  No
- Palpitations or consciousness of your heartbeat .....  Yes  No
- High blood pressure.....  Yes  No
- Rheumatic fever.....  Yes  No
- Pain or discomfort in the chest on exertion .....  Yes  No
- Shortness of breath on exertion .....  Yes  No
- Bronchitis or pneumonia .....  Yes  No
- Pleurisy or severe chest pain .....  Yes  No
- Coughing up blood or phlegm.....  Yes  No
- Chronic or persistent cough .....  Yes  No
- TB .....  Yes  No
- Pneumothorax .....  Yes  No
- Frequent chest colds or flu.....  Yes  No
- Asthma or wheezing .....  Yes  No
- Need to use a puffer or inhaler.....  Yes  No
- Operation on chest, lungs or heart .....  Yes  No
- Other chest complaint.....  Yes  No
- Indigestion, acid reflux or peptic ulcer .....  Yes  No
- Vomiting blood or passing red or black bowel motions .....  Yes  No
- Recurrent vomiting or diarrhoea .....  Yes  No
- Jaundice, hepatitis or liver disease.....  Yes  No
- Malaria or other tropical disease .....  Yes  No
- Severe loss of weight.....  Yes  No
- Hernia or rupture .....  Yes  No

Candidate's name .....

- Back injury.....  Yes  No
- Significant joint problem or sports injury.....  Yes  No
- Limitation of movement.....  Yes  No
- Fracture.....  Yes  No
- Paralysis or muscle weakness.....  Yes  No
- Kidney or bladder disease.....  Yes  No
- Diabetes.....  Yes  No
- Have you ever had, or do you now have or suffer from, any of the following?**
- Sickle cell disease.....  Yes  No
- Bleeding problem or other blood disease.....  Yes  No
- Skin disease.....  Yes  No
- Contagious disease.....  Yes  No
- Operations.....  Yes  No

List operations

**Doctor's use only**

**Other medical history: Have you—**

- been admitted to hospital?.....  Yes  No
- been rejected for life insurance?.....  Yes  No
- failed a medical examination?.....  Yes  No
- been unable to work on medical grounds?.....  Yes  No
- any other illness or health problem?.....  Yes  No

**Family history**

- Is there any family history of heart disease?.....  Yes  No
- Is there any family history of sudden death?.....  Yes  No
- Is there any family history of high cholesterol?.....  Yes  No
- Is there any family history of diabetes?.....  Yes  No
- Is there any family history of asthma or chest disease?.....  Yes  No
- Are you aware of any inherited diseases that run in your family?.....  Yes  No

**Females only**

- Are you now pregnant or planning to be?.....  Yes  No
- Do you have periods which incapacitate you or which may reduce your physical or mental performance?.....  Yes  No

I hereby authorize the examining doctor to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Candidate's name.....

**AS/NZS 2299.1 Occupational Diving Medical Examination—To be Completed by a Doctor Trained in Underwater Medicine**

**General appearance**

<b>Visual acuity</b>	Uncorrected	Corrected	Near vision	Colour perception	Height	Weight
Right	6/	6/			cm	kg
Left	6/	6/				
Waist measurement (cm)		Hip measurement (cm)		Ratio (W/H)		
<b>BP</b>	/	<b>Pulse</b>	/Min	<b>Urinalysis</b>		

		Notes and comments	
Head, Scalp, Face, Neck .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Ophthalmoscopy.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Pupils.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eye movements.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Visual fields.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Nose, Septum, Airway, Sinuses .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mouth, Throat, Teeth, Speech.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Ears—external.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Tympanic membrane	R.....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
	L.....	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Eustachian tubes (ear clearing)	R.....	<input type="checkbox"/> Easily with Valsalva	<input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/Unsatisfactory
	L.....	<input type="checkbox"/> Easily with Valsalva	<input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/Unsatisfactory
Chest & lung fields.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Cardiac auscultation .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Abdomen.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Lymph nodes.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Posture & gait.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Spine.....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Upper limbs .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Lower limbs .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Peripheral pulses.....		<input type="checkbox"/> Right Dorsalis Pedis	<input type="checkbox"/> Left Dorsalis Pedis
		<input type="checkbox"/> Right Post Tibial	<input type="checkbox"/> Right Post Tibial

Tendon reflexes	Absent	Weak	Mid-range	Brisk	Hyperreflexic	Notes and comments
Biceps	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Triceps	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
B/Rad	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Knee	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____
Ankle	R	_____	_____	_____	_____	_____
	L	_____	_____	_____	_____	_____

(mark line to indicate strength of reflex elicited)

Plantar reflexes Right..... Left.....

**AS/NZS 2299.1 Occupational Diving Medical Examination—To be Completed by a  
Doctor Trained in Underwater Medicine**

Candidate's name .....

Sensation.....  Normal  Abnormal

Cerebellar functions .....  Normal  Abnormal

Sharpened Romberg test Time stable .....(s)  Very stable  Major swaying/wobbles  
 A few minor sways/wobbles  Unable to hold balance

No. of attempts .....  Moderately unsteady

Emotional and psychiatric stability  Normal  Abnormal

Exercise tolerance.....  Fitness good—History  
 Fitness acceptable—History  
 Exercise test requested  
 Exercise test performed (specify type and result)

Chest X-ray .....  Normal  Abnormal Date..... Place .....

Lung function .....  Normal  Abnormal

Vital capacity.....

FEV1.....

Percentage.....

Audiometry

	Frequency, Hz							
Hearing level	500	1000	1500	2000	3000	4000	6000	8000
dB (R)								
dB (L)								

Tympanometry .....  Normal  Abnormal  Pending

Long Bone Survey .....  Not indicated  Recommended

Other tests .....  Nil required  Indicated (specify)

Other abnormalities .....  Nil noted  Noted (specify)

**NOTES—INCLUDE RESULTS OF ANY TESTS AND RISK ASSESSMENTS HERE:**

**AS/NZS 2299.1 Occupational Diver Medical Fitness Certificate**

I, \_\_\_\_\_, certify that

(Doctor's name)

\_\_\_\_\_

(Candidate's name)

has been assessed for medical fitness to dive in accordance with AS/NZS 2299.1:2015 and has been found—

- Fit to dive/work under pressure
- Permanently unfit
- Temporarily unfit—Review date.....
- Decision pending.....

**Categories of occupational diving for which fitness was assessed:**

- All occupational diving
- All occupational diving except saturation
- Other .....

**Advice provided:**

**Comments:**

I confirm that I have received formal training in the conduct of occupational diving medical examinations.

**Signed** .....

**Doctor's name (print)** .....

**Date** .....

**Candidate's signature** .....