

New Zealand Underwater Association (NZUA)

Qualified recreational divers health status screening questionnaire

This questionnaire is a screening tool for current divers. It has been designed to detect important medical risk factors in diving and therefore to determine whether a medical review is advisable. Its compilation involved a compromise between embracing all potentially relevant medical conditions, and simplicity and brevity. It follows that the emphasis is on important and relatively common conditions, and the questionnaire is not a comprehensive screen for all medical conditions that may be relevant to diving.

This questionnaire is, therefore, not intended to replace standard questionnaires used for SCUBA experience programmes or courses. It is not to be used as a screening questionnaire for entry into diving. Divers entering the sport should continue to utilise the RSTC medical statement questionnaire, or any other questionnaire used by the dive training agencies.

If you indicate 'yes' to any of the questions below you are advised to seek medical review. If you have been given this questionnaire prior to diving with an organised trip and answered 'yes' to any questions, then you are likely to be asked to either provide documentation of medical clearance to dive, or to undergo medical review prior to being accepted to dive. Please tick 'yes' or 'no' to all questions.

1. Do you have, or are you taking medication for, any of the conditions listed below?

	YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Major mental health disorder	<input type="checkbox"/>	<input type="checkbox"/>

(Such as schizophrenia, or severe depression, or psychosis)

2. Do you fall into the age category for recommended cardiovascular risk assessment screening (section A below) **AND** have **TWO OR MORE** of the additional risk factors for cardiovascular disease (section B below).

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

Section A: Are you in an age group where it is recommended that you have a medical assessment to determine your cardiovascular risk:

- Male aged over 45 years or a female aged over 55 years.
- A Maori, or a Pacific Islander from the Indian sub continent or Fiji, male older than 35 years, or female older than 45 years (ie: 10 years younger).

Section B: Do you have any of these additional risk factors?

- A family history of cardiovascular disease in a male parent or sibling aged under 55 years, or in a female relative less than 65 years of age
- A family history of diabetes in a parent or sibling
- A personal history of being a current or recent smoker (< 1 year)
- A personal history of high blood pressure (greater than 160/95 mmHg)
- A personal history of high cholesterol or abnormal blood lipids
- You are currently overweight (Defined as BMI ≥ 30 if known, or have a waist circumference of ≥ 100 cm in men or ≥ 90 cm women)
- A known previous impaired fasting glucose, or impaired glucose tolerance
- Females who have a personal history of gestational diabetes (diabetes during pregnancy)
- Females who have a personal history of polycystic ovary syndrome

NB: For general health review, regardless of whether you are a diver or not, cardiovascular risk assessment is recommended for all people who fall into either of the age categories in section A. For the purpose of this questionnaire, you will be asked to show evidence of medical clearance to dive only if you also have two or more of the additional risk factors in section B.

...continued overleaf

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|-----|---|------------------------------|-----------------------------|
| 3. | During exercise do you experience: undue breathlessness, chest pain or chest tightness, or wheeze? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. | Do you experience severe recurring headaches or migraines? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. | Do you have any conditions affecting your blood, such as anaemia, problems with clotting, or haemoglobin disorders? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. | Do you suffer problems with coordination or balance? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. | Do you experience intermittent palpitations (unusual beating sensations in your chest), or have you had an awareness of your heart racing for no apparent reason? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. | Do you frequently experience pain in, or have any difficulty equalising, your ears or sinuses when diving? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9. | Have you ever experienced any form of 'fit', 'turn', convulsion or unexplained fainting? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 10. | Do you have, or have you ever had, a severe respiratory illness (eg: sarcoid, lung cancer) or a lung injury (eg: collapsed lung – pneumothorax), or a severe chest infection (eg: pneumonia or TB)? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 11. | Do you have, or have you ever had, an illness which affects your nervous system (i.e: brain and/or nerves), such as Parkinsons disease, or Multiple Sclerosis? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 12. | Have you ever experienced numbness, tingling, weakness, or a feeling of heaviness in your limbs, after diving, which has not been reviewed by a diving doctor? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 13. | Have you ever been treated for decompression illness or another serious diving injury without subsequent medical clearance to dive? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 14. | Have you ever suffered any of the following?
Heart attack, stroke, or Transient Ischaemic Attack (TIA). | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 15. | Have you ever undergone surgery that involved your chest, lungs or heart? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 16. | In the last 5 years, have you suffered from a head injury that has caused you to lose consciousness? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 17. | Female divers only: Are you pregnant? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

DECLARATION BY DIVER:

I hereby declare that, to the best of my knowledge, the above details are true and correct.

Name (please print): _____

Signature: _____ Date: ____/____/____
Day/Month/Year

