DIVING MEDICAL EXAM OVERVIEW FOR THE EXAMINING PHYSICIAN

TO THE EXAMINING PHYSICIAN:

This person, _____________________, requires a medical examination to assess his/her fitness for certification as a Diver for the ___________________ University. His /her answers on the Diving Medical History Form (attached), may indicate potential health or safety risks as noted. Your evaluation is requested on the attached scuba Diving Fitness Medical Evaluation Report. If you have questions about diving medicine, you may wish to consult one of the references on the attached list or contact one of the physicians with expertise in diving medicine whose names and phone numbers appear on an attached list. Please contact the undersigned Diving Safety Officer if you have any questions or concerns about diving medicine or the Moss Landing Marine Laboratories diving medical standards. Thank you for your assistance.

Signature of Diving Safety Officer ____________________________
Diving Safety Officer's Printed Name ____________________________
Phone Number ____________________________

January 1, 2006

Scuba and other modes of compressed-gas diving can be strenuous and hazardous. A special risk is present if the middle ear, sinuses or lung segments do not readily equalize air pressure changes. The most common cause of distress is eustachian insufficiency. Most fatalities involve deficiencies in prudence, judgement, emotional stability or physical fitness. Please consult the following list of conditions which usually restrict candidates from diving.

(Adapted from Bove, 1998: 61 -63, bracketed numbers are pages in Bove)

CONDITIONS WHICH MAY DISQUALIFY CANDIDATES FROM DIVING

1. Abnormalities of the tympanic membrane, such as perforation, presence of a monomeric membrane, or inability to autoinflate the middle ears. [5,7,8,9]
2. Vertigo including Meniere's Disease. [13]
4. Recent ocular surgery. [15,18,19]
5. Psychiatric disorders including claustrophobia, suicidal ideation, psychosis, anxiety states, untreated depression. [20 - 23]
6. Substance abuse, including alcohol. [24-25]
7. Episodic loss of consciousness. [1, 26,27]
8. History of seizure. [27, 28]
9. History of stroke or a fixed neurological deficit. [29,30]
10. Recurring neurologic disorders, including transient ischemic attacks. [29,30]
11. History of intracranial aneurysm, other vascular malformation or intracranial hemorrhage. [31]
12. History of neurological decompression illness with residual deficit. [29,30]
13. Head injury with sequelae. [26, 27]
14. Hematologic disorders including coagulopathies. [41, 42]
15. Evidence of coronary artery disease or high risk for coronary artery disease ¹[33 - 35]
16. Atrial septal defects. [39]
17. Significant valvular heart disease - isolated mitral valve prolapse is not disqualifying. [38]
18. Significant cardiac rhythm or conduction abnormalities. [36 - 37]
19. Implanted cardiac pacemakers and cardiac defibrillators (ICD). [39, 40]
20. Inadequate exercise tolerance. [34]
21. Severe hypertension. [35]
22. History of spontaneous or traumatic pneumothorax. [45].
23. Asthma² [42 - 44]
24. Chronic pulmonary disease, including radiographic evidence of pulmonary blebs, bullae or cysts.[45,46]
25. Diabetes mellitus. [46 - 47]
26. Pregnancy. [56]


²“Are Asthmatics Fit to Dive? ” Elliott DH, ed. 1996 Undersea and Hyperbaric Medical Society, Kensington, MD.
MEDICAL EVALUATION OF FITNESS FOR SCUBA DIVING REPORT

Name of Applicant (Print or Type) ___________________________ Date (Mo/Day/Year) ___________________________

Date of Birth of Applicant (Mo/Day/Year)

To The PHYSICIAN:
This person is an applicant for training or is presently certified to engage in diving with self-contained underwater breathing apparatus (scuba). This is an activity which puts unusual stress on the individual in several ways. Your opinion on the applicant's medical fitness is requested. Scuba diving requires heavy exertion. The diver must be free of cardiovascular and respiratory disease. An absolute requirement is the ability of the lungs, middle ear and sinuses to equalize pressure. Any condition that risks the loss of consciousness should disqualify the applicant.

TESTS: Please initial that the following tests were completed.

[ ] Initial Examination [ ] Re-examination (Every 5 years under age 40, or first exam over age 40, every 3 years over age 40, every 2 years over age 60)

_____ Medical History
_____ Complete Physical Exam with emphasis on neurological and otological components

_____ Chest X-Ray
_____ Spirometry
_____ Hematocrit or Hemoglobin
_____ Urinalysis
_____ Any further tests deemed necessary by the physician

Additional testing for first over age 40 Additional testing for over age 40

_____ Resting EKG

_____ Assessment of coronary artery disease using Multiple-Risk-Factor Assessment

(age, lipid profile, blood pressure, diabetic screening, smoker)

_____ Resting EKG

_____ Assessment of coronary artery disease using Multiple-Risk-Factor Assessment

(age, lipid profile, blood pressure, diabetic screening, smoker)

Note: Exercise stress testing may be indicated based on risk factor assessment

1
2
RECOMMENDATION:

[ ] APPROVAL. I find no medical condition(s) which I consider incompatible with diving.

[ ] RESTRICTED ACTIVITY APPROVAL. The applicant may dive in certain circumstances as described in REMARKS.

[ ] FURTHER TESTING REQUIRED. I have encountered a potential contraindication to diving. Additional medical tests must be performed before a final assessment can be made. See REMARKS.

[ ] REJECT. This applicant has medical condition(s) which, in my opinion, clearly would constitute unacceptable hazards to health and safety in diving


REMARKS:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

I have discussed the patient's medical condition(s) which would not seriously interfere with diving but which may seriously compromise subsequent health. The patient understands the nature of the hazards and the risks involved in diving with these defects.

________________________________________ M.D. Date _____________________
Name (Print) ___________________________________________________________ M.D.
Address __________________________________________________________________
Telephone ________________________________________________________________
My familiarity with applicant is:

[ ] With this exam only

[ ] Regular Physician for _____ years

[ ] Other (describe) _____________________________________________________

__________________________________________________________________

My familiarity with diving medicine:

[ ] On attached list of physicians

[ ] Other (describe) _____________________________________________________

__________________________________________________________________

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APPLICANT'S RELEASE OF MEDICAL INFORMATION FORM

I authorize the release of this information and all medical information subsequently acquired in association with my diving to ____________________________________________ 's CSU Campus Diving Safety Officer and Diving Control Board or their designee.

Signature of Applicant __________________________ Date __________
DIVING MEDICAL HISTORY FORM  
(To Be Completed By Applicant-Diver)

Name ______________________________________   Sex ____ Age ___  Wt.___ Ht. ___

University ____________________________________________ Date ___/___/___
(Dept./Project/Program/School,etc.)  (Mo/Day/Yr)

TO THE APPLICANT:

Scuba diving makes considerable demands on your physical and emotional condition. Diving with particular defects amounts to asking for trouble not only for yourself, but to anyone coming to your aid if you get into difficulty in the water. Therefore, it is prudent to meet certain medical and physical requirements before beginning a diving or training program.

Your answers to the questions are more important, in many instances, in determining your fitness than what the physician may see, hear or feel when you are examined. Obviously, you should give accurate information or the medical screening procedure becomes useless.

This form shall be kept confidential. If you believe any question amounts to invasion of your privacy, you may elect to omit an answer, provided that you shall subsequently discuss that matter with your own physician and he/she must then indicate, in writing, that you have done so and that no health hazard exists.

Should your answers indicate a condition which might make diving hazardous, you will be asked to review the matter with your physician. In such instances, his/her written authorization will be required in order for further consideration to be given to your application. If your physician concludes that diving would involve undue risk for you, remember that he/she is concerned only with your well-being and safety. Please respect the advice and the intent of this medical history form.

<table>
<thead>
<tr>
<th>#</th>
<th>Yes</th>
<th>No</th>
<th>Have you ever had or do you presently have any of the following?</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>Trouble with your ears, including ruptured eardrum, difficulty clearing your ears, or surgery.</td>
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<td>2</td>
<td></td>
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<td>Trouble with dizziness.</td>
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<td>3</td>
<td></td>
<td></td>
<td>Eye surgery.</td>
<td></td>
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<td>4</td>
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<td></td>
<td>Depression, anxiety, claustrophobia, etc.</td>
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<td>5</td>
<td></td>
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<td>Substance abuse, including alcohol.</td>
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<td>6</td>
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<td>Loss of consciousness.</td>
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<td>7</td>
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<td>Epilepsy or other seizures, convulsions, or fits.</td>
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<td>8</td>
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<td>Stroke or a fixed neurological deficit.</td>
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<td>9</td>
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<td>Recurring neurologic disorders, including transient ischemic attacks.</td>
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<td>10</td>
<td></td>
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<td>Aneurysms or bleeding in the brain.</td>
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<tr>
<td>#</td>
<td>Yes</td>
<td>No</td>
<td>Have you ever had or do you presently have any of the following?</td>
<td>Comments</td>
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<td>11</td>
<td></td>
<td></td>
<td>Decompression sickness or embolism.</td>
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<td>12</td>
<td></td>
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<td>Head injury.</td>
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<td>13</td>
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<td>Disorders of the blood or easy bleeding.</td>
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<td>14</td>
<td></td>
<td></td>
<td>Heart disease, diabetes, high cholesterol.</td>
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<td>15</td>
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<td>Anatomical heart abnormalities including patent foramen ovale, valve problems, etc.</td>
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<td>16</td>
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<td>Heart rhythm problems.</td>
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<td>Need for a pacemaker.</td>
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<td>18</td>
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<td>Difficulty with exercise.</td>
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<td>19</td>
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<td>High blood pressure.</td>
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<td>20</td>
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<td>Collapsed lung.</td>
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<td>21</td>
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<td></td>
<td>Asthma.</td>
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<td>22</td>
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<td>Other lung disease.</td>
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<td>23</td>
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<td></td>
<td>Diabetes mellitus.</td>
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<td>24</td>
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<td>Pregnancy.</td>
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<td>25</td>
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<td>Surgery. If yes, explain below.</td>
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<td>26</td>
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<td>Hospitalizations. If yes, explain below.</td>
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<td>27</td>
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<td>Do you take any medications? If yes, list below.</td>
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<td>28</td>
<td></td>
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<td>Do you have any allergies to medications, foods, environmentals? If yes, explain below.</td>
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<td>29</td>
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<td>Do you smoke?</td>
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<td>30</td>
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<td>Do you drink alcoholic beverages?</td>
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<td>31</td>
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<td>Is there a family history of high cholesterol?</td>
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<td>32</td>
<td></td>
<td></td>
<td>Is there a family history of heart disease or stroke?</td>
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<tr>
<td>33</td>
<td></td>
<td></td>
<td>Is there a family history of diabetes?</td>
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<tr>
<td>34</td>
<td></td>
<td></td>
<td>Is there a family history of asthma?</td>
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Please explain any “yes” answers to the above questions.

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

I certify that the above answers and information represent an accurate and complete description of my medical history.

______________________________ _______________________
Signature Date