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AS/NZS 2299.1 Supp 1:2007

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# AS/NZS 2299.1 Supplement 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 N of AS/NZS 2299.1:2007.

This Joint Australian/New Zealand Standard Supplement was prepared by Joint Technical Committee SF-017, Occupational Diving. It was approved on behalf of the Council of Standards Australia on 12 July 2007 and on behalf of the Council of Standards New Zealand on 3 August 2007.
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The following are represented on Committee SF-017:

Association of Diving Contractors, New Zealand
Australian Council of Trade Unions
Australian Diver Accreditation Scheme
Australian Diving Contractors Association
Australian Industry Group
Australian Marine Sciences Association Inc
Australian Medical Association
Australian Seafood Industry Council
CSIRO Marine and Atmospheric Research
Department of Defence, Australia
Department of Labour, New Zealand
Department of the Premier and Cabinet, SA
Dive Queensland
Hyperbaric Engineering Industry Forum
Maritime Union of Australia
NSW Police Service
National Association of Occupational Diver Training Establishments, Australia
New Zealand Commercial Diver Training Council
New Zealand Underwater Association
Professional Divers Association of Australia
Royal New Zealand Navy
South Pacific Underwater Medicine Society
Underwater Visual Producers Association, Australia
Victoria Police
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We also welcome suggestions for improvement in our Standards, and especially encourage readers to notify us immediately of any apparent inaccuracies or ambiguities. Please address your comments to the Chief Executive of either Standards Australia or Standards New Zealand at the address shown on the back cover.

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## AS/NZS 2299 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 | | |

Type of Medical

- Unrestricted—including saturation
- Unrestricted—not including saturation
- Limited Occupational Diving—specify type ................................................
- Recreational Diving Industry work only

Do you participate in any regular physical activity: Rarely <1/week Weekly 2–3/week Most days
Type of physical activity:

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? Yes No
List:

Do you have any allergies? Yes No
List:

Have you ever had any reactions to drugs, medicines or foods? Yes No
List:

Next of kin name Relationship
Address
Phone number(s)

| **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 | |



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Candidate's name ..................................................

| Question | Answer | Doctor's use only |
|---|---|---|
| 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 | |
| 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 | |
| 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 | | |
| **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 | |
| **Other medical history** | | |
| Admitted to hospital .............................................. | ☐ Yes ☐ No | |
| Rejected for life insurance .................................... | ☐ Yes ☐ No | |
| Failed a medical examination................................ | ☐ Yes ☐ No | |
| Unable to work on medical grounds ...................... | ☐ Yes ☐ No | |
| Any other illness or health problem ....................... | ☐ Yes ☐ No | |
| **Family history** | | |
| Family history of heart disease.............................. | ☐ Yes ☐ No | |
| Family history of asthma or chest disease ............. | ☐ Yes ☐ No | |
| **Diving history to date** | | |
| Approx. date of first compressed air dive............... | | |
| Total hours under pressure .................................. | | |
| Types of diving experience: ☐ Scuba air ☐ Surface supply ☐ Saturation ☐ Scuba mix gas ☐ Surface deco ☐ Oxygen ☐ Hookah ☐ Bell diving | | |
| How many dives to date......................................... | | |
| Longest dive ............................................ | | |
| Deepest dive ........................................... | | |
| Have you ever suffered from— | | |
| ear squeeze?........................................... | ☐ Yes ☐ No | |
| sinus squeeze? ....................................... | ☐ Yes ☐ No | |
| decompression illness?............................ | ☐ Yes ☐ No | |
| headaches during or after dive? ................ | ☐ Yes ☐ No | |
| extreme tiredness after dive? .................... | ☐ Yes ☐ No | |
| Any other diving-related problems?........................ | ☐ Yes ☐ No | |
| If yes, specify ....................................................... | | |
| ........................................................................... | | |

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: ____________________



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Candidate's name………………………………………

# AS/NZS 2299 Medical Examination—Findings of Examination by Doctor Trained in Underwater Medicine

| General appearance |
|---|
| |

| Visual acuity | Uncorrected | Corrected | Near vision | Colour perception | Height | Weight |
|---|---|---|---|---|---|---|
| Right | 6/ | 6/ | | | cm | kg |
| Left | 6/ | 6/ | | | | |

**BP** / **Pulse** /min **Urinalysis**

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

| Tendon reflexes | | Absent Weak Mid-range Brisk Hyperreflexic | Notes & 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)



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Candidate's name…………………………………….

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

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 & psychiatric stability ☐ Normal ☐ Abnormal

Exercise tolerance ................................ ☐ Fitness good—History

☐ Fitness acceptable—History

☐ Exercise test requested

☐ Exercise test performed (specify type & result)

Chest X-Ray........................................ ☐ Normal ☐ Abnormal Date ………….. Place ……………………

Lung function....................................... ☐ Normal ☐ Abnormal

Vital capacity .......................................

$FEV_1$ ...................................................

Percentage..........................................

Audiometry

| Hearing level | Frequency, Hz | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 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:



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**AS/NZS 2299**

**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 2299.1:2007 and has been found—

☐ **Fit to dive/work under pressure**

☐ **Permanently unfit**

☐ **Temporarily unfit—Review date**.......

☐ **Decision pending** ..............................

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

☐ **All occupational diving**

☐ **All 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…………………………….



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