YOU MUST DOWNLOAD & TAKE THESE FORMS TO THE EXAM!

APPENDIX 1
University of Hawaii Diving Safety Program
Diving Medical Exam
Instructions for the Examining Physician
****PLEASE READ CAREFULLY****

TO THE EXAMINING PHYSICIAN: This person, ____________________________, requires a medical examination to assess his/her fitness for certification as a Scientific Diver for the University of Hawai‘i. His /her answers on the attached Diving Medical History Form 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, or if any response or test result is outside normal limits, you should consult with the University of Hawai‘i Diving Medical Officer. Please contact the undersigned Diving Safety Officer if you have any questions or concerns about this examination or the University of Hawai‘i standards. Thank you for your assistance.

David F. Pence, Diving Safety Officer
University of Hawaii - EHSO
2040 East-west Rd.
Honolulu, HI 96822
phone: (808) 956-9643  fax: 956-6952
dpence@hawaii.edu
http://www.hawaii.edu/ehso/diving-safety

Dr. Richard Smerz, Diving Medical Officer
Hawai‘i Hyperbaric Treatment Center
John A. Burns School of Medicine
Phone: (808) 587-3425

THIS EXAMINATION IS TO VERIFY THE FITNESS OF THE EXAMINEE TO ENGAGE IN OCCUPATIONAL DIVING. 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, judgment, 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. [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. Asthma. [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]

“Are Asthmatics Fit to Dive?” Elliott DH, ed. 1996 Undersea and Hyperbaric Medical Society, Kensington, MD.

SELECTED REFERENCES IN DIVING MEDICINE
Most of these are available from Best Publishing Company, P.O. Box 30100, Flagstaff, AZ 86003-0100, the Divers Alert Network (DAN) or the Undersea and Hyperbaric Medical Association (UHMS), Bethesda, MD.


Alert Diver Magazine; Articles on diving medicine http://www.diversalertnetwork.org/medical/articles/index.asp

“Are Asthmatics Fit to Dive? " Elliott DH, ed. 1996 Undersea and Hyperbaric Medical Society, Kensington, MD.


UNIVERSITY OF HAWAI’I DIVING SAFETY PROGRAM
APPENDIX 2
MEDICAL EVALUATION OF FITNESS FOR SCUBA DIVING REPORT

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

TO THE PHYSICIAN: This person is an applying, or is presently certified, to engage in diving with self-contained underwater breathing apparatus (SCUBA) in the workplace. This activity 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 or medication that risks the loss of consciousness should disqualify the applicant.

THE FOLLOWING ARE MINIMUM REQUIRED TESTS:

INITIAL EXAMINATION AND WHEN DEEMED NECESSARY BY PHYSICIAN

- Chest X-Ray
- Spirometry

INITIAL and PERIODIC RE-EXAM (Every 5 yr. Age 40 or less; Every 3 yr. Age 40 – 60; Every 2 yr. Age > 60)

- Medical History
- Complete Physical Exam, with emphasis on neurological and otological components
- Hematocrit or Hemoglobin
- Urinalysis
- Any further tests deemed necessary by the physician

PATIENT OVER AGE 40, AND AS DEEMED NECESSARY BY PHYSICIAN

- 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.

RECOMMENDATION (check one):

[ ] APPROVAL. As the basis for this recommendation, I have conducted and considered the results of all tests as specified above and find no medical condition(s) that 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.

[ ] NOT APPROVED. This applicant has medical condition(s), which, in my opinion, clearly would constitute unacceptable hazards to health and safety in diving.

REMARKS: ____________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

PHYSICIAN’S STATEMENT: I have evaluated the above-mentioned individual according to the University of Hawai’i medical standards for scientific diving as described in Appendix 1, and find no conditions that may be disqualifying. I have discussed with the patient any medical condition(s) that would not disqualify him/her from diving but which may seriously compromise subsequent health. The patient understands the nature of the hazards and the risks involved in diving with these conditions.

________________________________________, M.D. or D.O. __________________________
Signature Date

Name (Print or Type): __________________________________________________________________________

Address: ______________________________________________________________________________________

City, State, Zip: ______________________________ Telephone: ______________________________

My familiarity with applicant is: ____With this exam only ____Regular Physician for ___ years

____________________________________________________________________________________________

Other (describe) _____________________________________________________________________________

My expertise in diving medicine is: ____________________________________________________________________

NOTE: SIGNATOR MUST BE AN M.D. or D.O.
I authorize the release of all medical tests and information associated with this examination, and all medical information subsequently acquired in association with my diving under the auspices of the University of Hawaii to the UH Diving Safety Officer, Diving Control Board and/or their designee(s) at:

UH Diving Safety Program 
Environmental Health and Safety Office 
University of Hawaii at Manoa 
2040 East-West Rd. 
Honolulu, HI 96822

Signature of Applicant ___________________________ Date: __________

Applicant Printed Name ___________________________
APPENDIX 3
UNIVERSITY OF HAWAI’I DIVING MEDICAL HISTORY AND EXAMINATION FORM

Section 1, Diving Medical History Form (To Be Completed By Applicant-Diver)

Name _______________________________ Sex _____ DOB: ____________ Wt._______ Ht._______

Sponsor ______________________________ Date _____/_____/_____
(Dept./Project/Program/School, etc.) (Mo/Day/Yr)

Mailing Address: _____________________________________________________________________

Phone: (_____) __________________________ email: __________________________________________

TO THE APPLICANT:

Scuba diving makes considerable demands on you, both physically and mentally. Diving with certain medical conditions may be asking for trouble not only for yourself, but also for your buddy, other dive team members, or 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 below are as important in determining your fitness as your physical examination. 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 must 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.

Have you ever had or do you presently have any of the following? Please answer Yes or No. Explain affirmative responses under “Comments”.

Yes / No / NA  A. Has your medical history changed since your last diving medical examination?

Yes / No  1. Trouble with your ears, including ruptured eardrum, difficulty clearing your ears, or surgery.
Yes / No  2. Trouble with dizziness.
Yes / No  3. Eye surgery.
Yes / No  4. Depression, anxiety, claustrophobia, etc.
Yes / No  5. Substance abuse, including alcohol.
Yes / No  6. Loss of consciousness.
Yes / No  7. Epilepsy or other seizures, convulsions or fits.
Yes / No  8. Stroke or a fixed neurological deficit.
Yes / No  9. Recurring neurologic disorders, including transient ischemic attacks.
Yes / No  10. Aneurysms or bleeding in the brain.
Yes / No  11. Decompression sickness or embolism.
Yes / No  12. Head injury
Yes / No  13. Disorders of the blood, or easy bleeding.
Yes / No  14. Heart disease, diabetes, high cholesterol
Yes / No  15. Anatomical heart abnormalities including patent foramen ovale, valve problems, etc.
Yes / No  16. Heart rhythm problems.
Yes / No  17. Need for a pacemaker
Yes / No  18. Difficulty with exercise.
Yes / No  19. High blood pressure
Yes / No  20. Collapsed lung
Yes / No  21. Asthma.
Yes / No  22. Other lung disease.
Yes / No  23. Diabetes mellitus.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes / No</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Surgery If yes explain below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Hospitalizations. If yes explain below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Do you take any medications? If yes list below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Do you have any allergies to medications, foods, or environmentals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Do you smoke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Do you drink alcoholic beverages?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Is there a family history of high cholesterol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Is there a family history of heart disease or stroke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Is there a family history of diabetes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Is there a family history of asthma?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain any “yes” answers to the above questions:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

DIVER’S CERTIFICATION: I certify that the above answers and information represent an accurate and complete description of my medical history.

Signature: ____________________________ Date: ________________
Section 3. MEDICAL EXAMINATION. To be completed by the Doctor.

Last Name: ___________________________ First Name: ___________________________ M.I.: _______
Date of Birth: ____________________ Sex: _______ Height: ____________  Weight: ____________

MEDICAL HISTORY REVIEW: Is there any significant past history, or current condition or medication, which might disqualify the applicant for diving? Yes  / No
Remarks: ______________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

General Appearance: ____________________________________________________________________
Blood Pressure: ____________________________ Pulse: __________________
Vision: Uncorrected: R/_______ L/_______ Corrected: R/_______ L/_______
Color Test: __________________________ Normal __________________________ Deficient.

EXAMINATION: Please check all items and, if abnormal, give details.

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head and neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Nose, Sinuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ear Canals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ear Drums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ear clearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Webber, Rinne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Fundi, Disks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Pupils, ECM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Peripheral visions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Mouth and Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Neck, Nodes/mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Axillary Nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Back and Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Heart Sounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Heart rhythm, size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Abdomen LS &amp; K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Genitalia, nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Cremasteric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. DTR’s Tricep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. DTR’s Bicep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. DTR’s Knee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. DTR’s Ankle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Plantar Reflex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Sensory, noxious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Sensory, fine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Sensory, vib</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Heel/Toe Walk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Romberg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Fast Pointing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Finger - Nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Rapid Movement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Squat</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Emotional Stability: ________________________________________________________________

Apparent Diving Aptitude: _________________________________________________________

Breath hold Duration: _____________________________________________________________

Signature: ________________________________, Examiner  Date: ______________________

Print or Type Name: ___________________________________________________________

Address: ______________________________________________________________________

Phone: (______) ____________________________