ANNEX I

Questionnaire on the state of health for the practice of recreational diving

Diving requires good physical and mental health. There are some medical conditions that can be dangerous during the practice of diving, and which are listed below. Those who have or are predisposed to any of these conditions should be evaluated by a doctor. This Diver's Doctor Questionnaire provides a basis for determining whether you should seek such an evaluation. If you have any concerns about your fitness for scuba diving and are not represented on this form, please consult with your doctor before diving. References to "diving" on this form cover both recreational diving with self-contained equipment and freediving. This form is primarily designed as an initial medical examination for new divers, but is also appropriate for divers receiving continuing education. For your safety and that of others who may dive with you, answer all questions honestly.

INSTRUCTIONS

Complete this questionnaire as a prerequisite for freediving or scuba diving training with autonomous equipment.

Note to women: If you are pregnant, or trying to get pregnant, **do not dive.**

1. I have had problems with my lungs or breathing, heart or blood.	Yes □ Go to Table A	No □
2. I am over 45 years old.	Yes □ Go to Table B	No □
3. I have trouble doing moderate exercise (for example, walking 1.6 kilometers in 12 minutes or swimming 200 meters without rest), or I have not been able to participate in normal physical activity due to reasons of physical condition or health in the last 12 months.	Yes □ *	No □
4. I have had problems with my eyes, ears, or nostrils or sinuses.	Yes □ Go to table C	No □
5. I have had surgery in the past 12 months, or I have ongoing problems related to a previous surgery.	Yes □*	No □
6. I've lost consciousness, had migraine headaches, seizures, accident cerebrovascular, significant head injury, or I have suffered from neurological injury or disease persistent.	Yes □ Go to table D	No □
7. I have had psychological problems, been diagnosed with a learning disability, personality disorder, panic attacks, or an addiction to drugs or alcohol.	Yes □ Go to table E	No □
8. I have had back problems, hernia, ulcers or diabetes.	Yes □ Go to table F	No □
9. I have had stomach or intestinal problems, including recent diarrhea.	Yes □ Go to table G	No □
10. I am taking prescription medications (with the exception o contraceptives or antimalarial drugs).	Yes □*	No □

Participant's Signature

If you answered NO to the 10 questions above, no medical evaluation is required. Please read and accept the Declaration of the participant below with the date and his signature.

Participant Statement: I have answered all questions honestly, and I understand that I accept the liability for any consequences resulting from any questions you may have answered inaccurately or for failing to disclose any existing or past health conditions.

Date (dd/mm/yyyy)

Signature of participant (or, if minor, signature of participant's parent/guardian is required.)

Participant's name Date of birth (dd/mm/yyyy)

Instructor Name Name of the dive center

* If you answered YES to questions 3, 5 or 10 above or to any of the questions on page 2, read and accept the previous statement with the date and your signature, and take the Physician's Evaluation Form to your physician, for a Medical evaluation. Participation in a scuba training program requires evaluation and approval from your doctor.

Participant's name ____
Date of birth ____
Diver's Medical Report | Participant Questionnaire (confidential)

Table A - I have/have had:		
Thoracic surgery, heart surgery, heart valve surgery, stenting or pneumomotorax (lung collapsed).	Yes □*	No
Asma, sibilancias, alergias graves, fiebre del heno o vías respiratorias congestionadas en los últimos 12 meses que limite mi actividad física o ejercicio.	Yes □*	No
A problem or disease involving my heart such as: angina, chest pain in the exertion, heart failure, pulmonary edema, cardiomyopathy or stroke, or I am taking medicines for any heart condition.	Yes □*	No
Recurrent bronchitis and persistent cough in the past 12 months, or have been diagnosed with emphysema.	Yes □*	No
Table B - I am over 45 years old and:		
I currently smoke or inhale nicotine by other means.	Yes □*	No
I have a high cholesterol level.	Yes □*	No
I have high blood pressure.	Yes □*	No
I have had a family member (1st or 2nd degree of consanguinity) who died of sudden death or illness heart or stroke before age 50, or I have a family history of illness heart before age 50 (including abnormal heart rhythms, coronary artery disease, or cardiomyopathy)	Yes □*	No
Table C - I have/have had:		
Sinus surgery in the past 6 months.	Yes □*	No
Sinus surgery in the past 6 months.	Yes □*	No
Recurrent sinusitis in the past 12 months.	Yes □*	No
Eye surgery in the past 3 months.	Yes □*	No
Table D - I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes □*	No
Persistent neurological injuries or diseases.	Yes □*	No
Recurrent migraine headaches in the past 12 months, or taking medication to prevent them.	Yes □*	No
Fainting or fainting (total/partial loss of consciousness) in the past 5 years.	Yes □*	No
Epilepsy, seizures, or seizures, or I take medicines to prevent them.	Yes □*	No
Table E - I have/have had:		
Behavioral health, mental or psychological problems that require medical or psychiatric treatment.	Yes □*	No
Major Depression, suicidality, panic attacks, uncontrolled bipolar disorder requiring Psychiatric medication/treatment.	Yes □*	No
I have been diagnosed with a mental health condition or a learning or developmental disorder that It requires ongoing attention.	Yes □*	No
A drug or alcohol addiction that requires treatment within the past 5 years.	Yes □*	No
Table F - I have/have had:		
Recurrent back problems in the last 6 months that limit my daily activity.	Yes □*	No
Back or spine surgery in the past 12 months.	Yes □*	No
Diabetes, either controlled by insulin or diet, or qestational diabetes in the past 12 months.	Yes □*	No
An uncorrected hernia that limits my physical abilities.	Yes □*	No
Active or untreated ulcers, problematic wounds, or ulcer surgery in the past 6 months.	Yes □*	No
Table G - I have:		
Ostomy surgery and I am not medically cleared to swim or participate in physical activity.	Yes □*	No
Dehydration requiring medical intervention in the past 7 days.	Yes □*	No
Active or untreated stomach or intestinal ulcers or ulcer surgery in the past 6 months.	Yes □*	No
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes □*	No
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes □*	No
Bariatric surgery in the last 12 months.	Yes □*	No

Diver's Medical Report | Physician Evaluation Form

Participant Name ____

Date of birth_______________________________________

(Uppercase) Date (dd/mm/yyyy)

The person mentioned above requests your opinion on your medical suitability to participate in the Diving training or activity.

Outcome of the Evaluation

□ **Apt- I do not find conditions that I consider incompatible with diving.**
□ **Not Fit - I find conditions that I consider incompatible with diving.**

Physician's Signature Date (dd/mm/yyyy)

Doctor's Name _______________________________________
Speciality____
(Uppercase)

Medical Center/Hospital ___________________________________
Address____
Phone _________________________ **Email** ____

Doctor/Hospital Seal (optional)