New DAN/RSTC Scuba Diver Health Certificate

New Scuba Medical Form

- As of June 2020, DAN, PADI, the Recreational Scuba Training Council (RSTC), and the Undersea Hyperbaric and Medical Society (UHMS) have cooperated on a new Scuba Medical Health Form.
- Old Form designed in 1989!
- The form is designed to be simpler to understand and fill out using only 1 page unless you answer “Yes” to certain questions.
- It incorporates reference to COVID-19 and expands the Medical Guidance to Physicians (From 4 to 12 pages)

New Scuba Medical Form

The new system has three components:

1. **<u>Diver Medical Participant Questionnaire</u> is completed by the diving candidate. (Pages 1 and 2)**
2. **<u>Diver Medical Physician's Evaluation Form</u> is completed by the physician evaluating the diving candidate for diving suitability when a physician's evaluation to dive is recommended. (Page 3)**
3. **<u>Diving Medical Guidance to the Physician</u> is a peer reference for physicians seeking additional information regarding how specific conditions relate to diving.**

The first two pages of the document are the questionnaire, and the third page is the section the physician would complete if the diver answers "Yes" to any of the statements.

The Diving Medical Guidance to the Physician is an online document hosted on a dedicated page on the Undersea & Hyperbaric Medical Society (UHMS) website. (https://www.uhms.org/resources/recreational-diving-medical-screening-system.html)

DAN Recommendation on Medical Fitness

Schedule for Lifelong Medical Fitness to Dive Evaluation

Who	When	What
Candidates for entry level OR Continuous education training	Pre-participation	Diver Medical Participant Questionaire
Healthy divers	Annually	Diver Medical Participant Questionaire
Asymptomatic divers with 2 or more risk factors (Smoking or vaping, high blood pressure, high cholesterol, obesity, family history of heart disease or premature death, lack of exercise	Every 5 years	Medical Evaluation (Diver Medical Physical Evaluation Form)
Healthy divers > 45 years of age		
Healthy divers >65 years of age	Every year	Medical Evaluation (Diver Medical Physical Evaluation Form)
Pre-existing diseases of heart, lungs, blood, metabolism, neuro-psychiatric conditions or any other disease that affects your capacity to exercise or effectively dive without assistance		
Acute illness: Do not dive. See healthcare provider as needed.	After regaining pre-illness exercise capacity, before return to diving	Diver Medical Participant Questionaire

DAN | WRSTC | RSTC | R·S·T·C Europe | Undersea & Hyperbaric Medical Society

Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.

Note to women: If you are pregnant, or attempting to become pregnant, *do not dive.*

Question	Yes	No
1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.	Yes ☐ *Go to Box A*	No ☐
2. I am over 45 years of age.	Yes ☐ *Go to Box B*	No ☐
3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes ☐*	No ☐
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes ☐ *Go to Box C*	No ☐
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes ☐*	No ☑
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes ☐ *Go to Box D*	No ☐
7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability.	Yes ☐ *Go to Box E*	No ☐
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ *Go to Box F*	No ☐
9. I have had stomach or intestine problems, including recent diarrhea.	Yes ☐ *Go to Box G*	No ☐
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes ☐*	No ☐

Participant Signature

If you answered *NO* to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

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

Participant Signature (or, if a minor, participant's parent/guardian signature required.) ______ Date (dd/mm/yyyy) ______

Participant Name (Print) ______ Birthdate (dd/mm/yyyy) ______

Instructor Name (Print) ______ Facility Name (Print) ______

* **If you answered *YES*** to questions 3, 5 or 10 above ***OR*** to any of the questions on page 2, please read and agree to the statement above by signing and dating it ***AND* take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

8.50 x 11.00 in

Participant Name ____________________ (Print) Birthdate ____________ Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

Box A – I have/have had:		
Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	Yes ☐*	No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐*	No ☐
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes ☐*	No ☐
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes ☐*	No ☐
A diagnosis of COVID-19.	Yes ☐*	No ☐

Box B – I am over 45 years of age 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 close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes ☐*	No ☐

Box C – I have/have had:		
Sinus surgery within the last 6 months.	Yes ☐*	No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐*	No ☐
Recurrent sinusitis within the past 12 months.	Yes ☐*	No ☐
Eye surgery within the past 3 months.	Yes ☐*	No ☐

Box D – I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes ☐*	No ☐
Persistent neurologic injury or disease.	Yes ☐*	No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐*	No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes ☐*	No ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

Box E – I have/have had:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐*	No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐*	No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes ☐*	No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐*	No ☐

Box F – I have/have had:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐*	No ☐
Back or spinal surgery within the last 12 months.	Yes ☐*	No ☐
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes ☐*	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐*	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐*	No ☐

Box G – I have had:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐*	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐*	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 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 within the last 12 months.	Yes ☐*	No ☐

*Physician's medical evaluation required (see page 1).

Diver Medical | Physician's Evaluation Form

Participant Name ______________________ Birthdate ______________
(Print) Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

- ☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.
- ☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

______________________ ______________
Physican's Signature Date (dd/mm/yyyy)

Physician's Name ______________________ Specialty ______________
(Print)

Clinic/Hospital ______________________

Address ______________________

Phone ______________ Email ______________

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego

Lung, Heart, COVID 45+

1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19.	Yes ☐ *Go to Box A*	No ✓
2. I am over 45 years of age.	Yes ✓ *Go to Box B*	No ☐

Box A – I have/have had:		
Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	Yes ☐*	No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐*	No ☐
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes ☐*	No ☐
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes ☐*	No ☐
A diagnosis of COVID-19.	Yes ☐*	No ☐

Box B – I am over 45 years of age 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 close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes ☐*	No ✓

Physical Conditioning / EENT Issues

3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes ☐*	No ☑
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes ☐ *Go to Box C*	No ☑

Box C – I have/have had:		
Sinus surgery within the last 6 months.	Yes ☐*	No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐*	No ☐
Recurrent sinusitis within the past 12 months.	Yes ☐*	No ☐
Eye surgery within the past 3 months.	Yes ☐*	No ☐

Surgery / Head, Seizure, Migraine, Etc

5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes ☑ *	No ☐
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes ☐ *Go to Box D*	No ☑

Box D – I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes ☐*	No ☐
Persistent neurologic injury or disease.	Yes ☐*	No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐*	No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes ☐*	No ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

Psychological / Back, Hernia, Ulcers & Diabetes

7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability.	Yes ☐ *Go to Box E*	No ✓
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ *Go to Box F*	No ✓

Box E – I have/have had:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐*	No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐*	No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes ☐*	No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐*	No ☐

Box F – I have/have had:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐*	No ☐
Back or spinal surgery within the last 12 months.	Yes ☐*	No ☐
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes ☐*	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐*	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐*	No ☐

Stomach / Intestines

9. I have had stomach or intestine problems, including recent diarrhea.	Yes ☐ *Go to Box G*	No ☑
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes ☑ *	No ☐

Box G – I have had:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐*	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐*	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 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 within the last 12 months.	Yes ☐*	No ☐

Participant Signature

Participant Signature

If you answered *NO* to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

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

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

Date (dd/mm/yyyy)

Participant Name (Print)

Birthdate (dd/mm/yyyy)

Instructor Name (Print)

Facility Name (Print)

* **If you answered *YES*** to questions 3, 5 or 10 above ***OR*** to any of the questions on page 2, please read and agree to the statement above by signing and dating it ***AND* take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

Resources for Your Physician

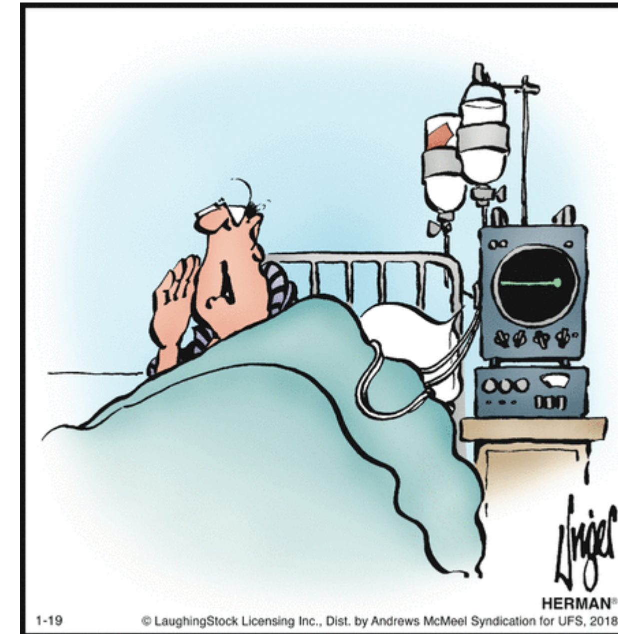
- UHMS Diving Medical Guidance to the Physician.
- DAN Medical Information:
  - DAN Medical FAQ's
  - DAN Medical Articles
- Other Medical Community References.

UHMS Diving Medical Guidance

Diving Medical Guidance

Diving Medical Guidance to the Physician

These guidelines are typically used by physicians who have been approached by an individual wishing to take part in recreational scuba diving or freediving. They will usually have completed a WRSTC Diver Medical Participant Questionnaire.



"Excuse me. The machine is making a funny noise and the little light is going in a straight line."

The following sections are included in this document (click to jump to section):

BEHAVIORAL HEALTH CARDIOVASCULAR SYSTEMS GASTROINTESTINAL HEMATOLOGICAL
METABOLIC AND ENDOCRINOLOGICAL NEUROLOGICAL ORTHOPEDIC OTOLARYNGOLOGICAL PULMONARY

UMHS Guidance Excerpt

UHMS Provides a Summary Discussion of Topic identifies "Severe" and "Relative" Risk Conditions.

PULMONARY

Severe Risk Conditions

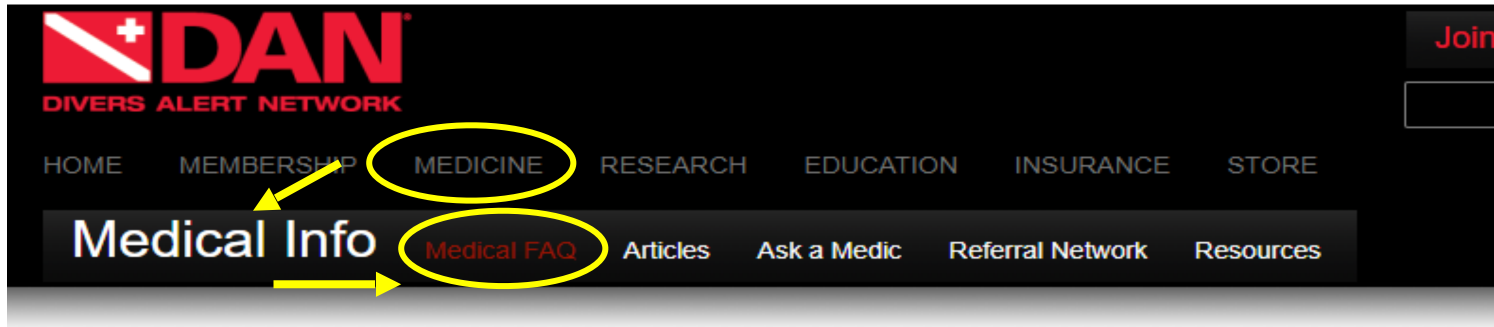
- History of spontaneous pneumothorax (see notes)
- Impaired exercise performance due to respiratory disease
- Respiratory impairment secondary to cold gas breathing
- Pulmonary hypertension

Relative Risk Conditions

- Asthma, reactive airway disease (RAD), exercise-induced bronchospasm (EIB) or COPD (
- Solid, cystic or cavitating lesion
- Pneumothorax secondary to:
  - Thoracic surgery
  - Trauma or pleural penetration (see notes)
  - Previous overinflation injury
- Obesity
- History of immersion pulmonary edema or restrictive disease
- Interstitial lung disease: may increase the risk of pneumothorax and likely to limit exertion
- Sleep apnea

"That's not what it says on the Web."

DAN Medical Frequently Asked Questions



DAN Medical Frequently Asked Questions

Aging

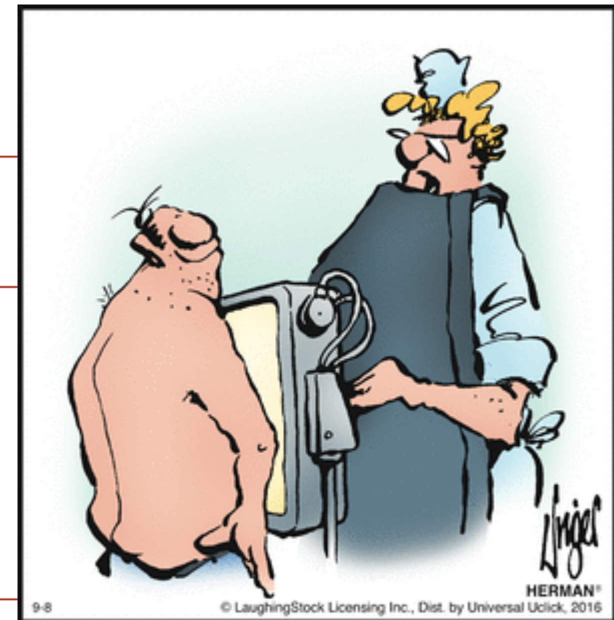
- Diving After Joint Replacement
- The Aging Divers

Barotrauma

- Ear Squeeze (Ear Pain)
  Dealing with Middle Ear Barotrauma
- Mask Squeeze
  Not just a dilemma for new divers, DAN takes an in-depth, in-your-face look at it.
- Mechanism of Injury for Pulmonary Over-Inflation Syndrome
- Nosebleeds (Sinus Squeeze)
  DAN explains why new divers frequently get nosebleeds.

Cardiovascular (Heart)

- ACE Inhibitors (Angiotension-converting enzyme)
  Cardiovascular Medications
- Atrial Septal Defects (ASD)



"You don't have to keep smiling for a chest X-ray."

DAN Medical FAQ's

- Aging
- Barotrauma
- Cardiovascular
- Diabetes & Diving
- Diving Accidents
- Ears, Nose & Throat
- Endocrine
- Fitness to Dive
- Gastrointestinal
- General
- Musculoskeletal
- Neurological
- Ophthalmology
- Plastic Surgery
- Women in Diving

Diver Medical | Physician's Evaluation Form

Participant Name ______________________ Birthdate ______________
(Print) Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

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

Physician's Name ______________________ Specialty ______________
(Print)

Clinic/Hospital ______________________

Address ______________________

Phone ______________ Email ______________

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego

DAN Recommendation on Medical Fitness

Schedule for Lifelong Medical Fitness to Dive Evaluation

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Healthy divers >65 years of age	Every year	Medical Evaluation (Diver Medical Physical Evaluation Form)
Pre-existing diseases of heart, lungs, blood, metabolism, neuro-psychiatric conditions or any other disease that affects your capacity to exercise or effectively dive without assistance		
Acute illness: Do not dive. See healthcare provider as needed.	After regaining pre-illness exercise capacity, before return to diving	Diver Medical Participant Questionaire

Summary

- DAN recommendation relating to 45+ and 65+ divers likely to be noted by Operators and Resorts.
- Recommended, but not YET Required, to use the new form.
- However, recommended that Dive Professionals transition as soon as practical.
- When you use it and need to get your doctor's certification, provide all 12 pages of the UMHS Medical Guidance, or the Link to your Provider.

Discussion

CARTOONSTOCK
Search ID: mlyn3190