

SAUHMA

Address: The Rosen Office Park, DAN Building, C/O Invicta & Third Roads, Midrand, 1685
Phone: (011) 266-4901. Fax: (011) 312-0054

WEBSITE: www.sauhma.org

DIVE MEDICAL REPORT

PERSONAL INFORMATION									
1. Surname			First name(s)						
2. Physical address			:	:					
		Postal code							
3. Contact no's	Cell phone No & International Pres	fix:	E-mail:						
		Ī							
4. Date of birth		5.	Nationality						
6. ID/P-port no.				Gender		8. Age			
9. Diver Class	I II mix gas	II air IV mix gas	air mix gas	Supervis	sor Instructor	Technical	Recrea- tional		
10. Previous Medi	cal examination / date:								
11. Have you ever had a diving medical assessment denied, suspended, revoked or referred for panel opinion?									
12. Have you EVE	R had any diving related accident, injury	y, illness or problem, espe	ecially since your last n	nedical?			Y N		
13. Average weekly alcohol consumption in units (1unit= 340ml beer /1Tot measure spirit/1 glass wine):									
14. Smoking? Y Consumption: sticks/day Previous smoker: sticks/day. Year stopped:					Never				
15. Currently using ANY Medication, Sub-stances or Therapy? N Yes, list names:									
16. ANY implants	/ devices?	N Yes, pleas	se elaborate:						
17. Exercise: Type	e, frequency, intensity								
18. Diving Experience: Frequency, No Dives									
Use space below to explain any of the above that require clarification / DOCTOR's NOTES:									

MEDICAL HISTORY Do you have, or have you ever had, any of the following? Tick Yes or No. Circle appropriate response if more than one option is given. If unsure, leave blank. Υ Ν 23. ANY mental illness or mental health issues requiring medication or 1a. Eye disorders/ Eye surgery / Corrective lenses intervention (counselling) 1b. Corrective aid: prescription changed since last medical? 24. Drug / Substance abuse or addiction. Mention recreation use please 2. Sinus problems, hay fever or allergies 25. Musculoskeletal impairment or impaired mobility 26. Stomach / Liver / Gall tract / Bowel disorders. Hernia? 3. Nose & throat/ Speech problems 4. Dental problems / dentures / dental surgery 27. Hormonal disorders: particularly diabetes 5. Ear: deafness / injury / discharge / surgery to ears 28. Renal problems: blood in urine / history of kidney stones. 29. Vomiting blood or passing blood on bowel motions 6. Ear issues or Headache when flying 7. Motion sickness, severe enough to require medication 30. Blood disorders: anaemia, sickle cell, clotting disorders 8. ANY shortness of breath / cough / wheezing / lung disorders 31. Gynaecological issues (menstrual, pregnancy, ovarian, etc) 9. History of pneumothorax (collapsed lung), penetrating chest 32. Prostate problems injuries or open chest surgery 10. History of Immersion Pulmonary oedema or shortness of 33. Sexually transmissible diseases breath in the water. 11. ANY Heart disease incl blood vessel, valve or muscle 34. Tropical diseases: Malaria, Cholera, Dengue 12. Racing or irregular heart beat 35. Infective diseases: HIV, Hepatitis, Tuberculosis 36a. Have you been diagnosed with Covid OR had suspicious symptoms of 13. Chest pain or discomfort on exercise Covid during the last 2 years 14. Blood pressure problems - high OR low 36b. Have you been vaccinated against Covid 15. High cholesterol 37. Cancers / Malignancies 38. Admission to hospital NOT related to elective surgery 16. Blood clots in legs, lungs or history of stroke 17. Sleep apnoea/severe snoring/waking up tired or breathless 39. Known allergies 40. ANY OTHER ILLNESS, INJURY or OPERATION NOT MENTIONED 18. Head injury. Concussion or CT or MRI scan investigations **ABOVE** 41. Any visit to your doctor since your last dive medical? 19. Sever / frequent headaches; including migraine 20. Light headedness/dizziness/unconsciousness for ANY reason 42. Refusal for granting life insurance cover 43. Refusal or revocation of diving fitness/ 21. Neurological: epilepsy, seizures, paralysis, numbness 22. Claustrophobia 44. Recipient of incapacity OR compensation pay for injury/illness **FAMILY HISTORY OF:** Υ Υ N N 51. Diabetes 45. Heart disease, blood vessel disease or rhythm disorders 46. Sudden death at young age 52. Tuberculosis 47. High blood pressure 53. Allergy / Asthma / Eczema 48. High cholesterol 54. Inherited disorders 49. Epilepsy 55. Glaucoma 50. Mental illness or psychiatric treatment

REMARKS/EXPLANATIONS OF ALL RESPONSE ANSWERED 'Yes':								
I hereby declare that I have carefully considered the statements I have made above and that to the best of my belief they are complete and correct. I further declare that I have not withheld any relevant information or made any misleading statements. I understand that if I have made any false or misleading statement in connection with this application, or if I do not consent to release the supporting medical information, the Authority may refuse to grant me medical clearance or may withdraw any medical clearance granted, without prejudice to any other legal action applicable.								
Consent to release of medical information: I hereby give my consent that all relevant medical information may be released and submitted to the medical assessor of the Licensing Authority.								
Note: Medical Confidentiality will be respected all times.								
SIGNATURE OF APPLICANT	NAME IN BLOCK LETTERS	DATE	SIGNATURE OF DMP (AS WITNESS)					