MEDICAL ASSESSMENT FORMS – COMMERCIAL/OCCUPATIONAL DIVING

CONFIDENTIAL: A diver must not participate in any diving operation if he/she is physically or emotionally fatigued or has used drugs or alcohol that could impair his/her diving abilities.

Last Name:	Exam Date:	Month:	Day:	Year:
First Name:	Gender:		Social Insurance Number:	
Home Address:	Date Of B		Day:	Year:
City:	Province:		Postal Code:	
Phone:	Email:			
Mailing Address (if different from above):				

OHIP Number:	Version:	Secondary Insurance Number:

Family Physcian:		
Address:	City:	
Province:	Postal Code:	Phone:

Employer:		
Address:	City:	
Province:	Postal Code:	Phone:

Location of Diving Operations:

Dr. Suneel Upadhye
MD MSc FRCPC
DCBC Level II Physician

suneel@thediveacademy.ca

The Dive Academy
1380 Speers Road, Unit 10, Oakville, Ontario, L6L 5V3

Phone: (905) 847-9595
Fax: (905) 845-2899
www.thediveacademy.ca

Signed

Date

MEDICAL ASSESSMENT FORMS – COMMERCIAL/OCCUPATIONAL DIVING

OCCUPATIONAL HISTORY
A. DIVING

How long have you been diving, including recreational diving?

How long have you been employed as an Occupational Diver and Where?

Date of last Occupational Diver Medical Exam:	Performed by?	Location?
Date of last Long Bone Xray:	Performed by?	Location?

Have you ever been rejected from diving due to medical reasons? If yes, please provide details:

DETAILS ON CURRENT OCCUPATIONAL DIVING WORK:

Type of diving:

☐ Decompression ☐ Bounce (Yo-Yo) ☐ Contaminated ☐ Saturation

Type of diving equipment used:

☐ Scuba ☐ Surface Supply ☐ Hookah ☐ Rebreather

Type of breathing medium:

☐ Air ☐ Enriched Air/Nitrox ☐ Mixed Gases (other than nitrox) details?

Purpose of diving:

☐ Scientific ☐ Inspection ☐ Fish Farms ☐ Seafood Harvesting

☐ Police/Fire ☐ Salvage ☐ Construction ☐ Other (please specify)

In the past five years, state: (please specify Depth in feet or meters and Bottom Time in minutes)

Deepest Occupational Dive	Depth		Bottom Time		Year
Deepest Recreational Dive	Depth		Bottom Time		Year
Longest Occupational Dive	Depth		Bottom Time		Year
Longest Recreational Dive	Depth		Bottom Time		Year

Since your last diving medical, state:	Occupational	Recreational
Average number of dives per day		
Average number of dives per week		
Average depth of dives		
Average bottom time of dives		

OCCUPATIONAL HISTORY
B. EMPLOYMENT OTHER THAN DIVING

Previous Work Experience:

Other current jobs (if only diving part time or seasonal):

Have you had any work related heath problems from current or previous non-diving employment? (if yes, give details)

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DIVING MEDICAL HISTORY

Have you ever had any of the following disorders during or after diving (occupationally or recreationally)?

Issue/Disorder	Yes/No	If yes, please provide details
Severe pain in ears or face	☐Yes/No☐	
Rupture of ear drum	☐Yes/No☐	
Lung squeeze	☐Yes/No☐	
Rupture of lung (burst lung)	☐Yes/No☐	
Pneumothorax, Pneumomediastinum	☐Yes/No☐	
Subcutaneous Emphysema	☐Yes/No☐	
Air Embolism	☐Yes/No☐	
Decompression Sickness (Bends)	☐Yes/No☐	
Bone Necrosis / Dysbaric Osteonecrosis	☐Yes/No☐	
Symptoms such as visual disturbances, ringing in the ears, nausea, vomiting, giddiness, dizziness, irritability, disorientation, twitching, staggering	☐Yes/No☐	
Any other diving injury / illness	☐Yes/No☐	
Have you ever filed a WCB claim while employed as a diver?	☐Yes/No☐	
If yes, was it directly related to your underwater diving activities?	☐Yes/No☐	
Where did this incident occurr?		

FAMILY MEDICAL HISTORY

Is there a history of any of the following issues in members of your family?

Issue/Disorder	Yes/No	If yes, please provide details
Allergies	☐Yes/No☐	
Asthma	☐Yes/No☐	
Pneumothorax	☐Yes/No☐	
Heart circulation problems (hypertrophy cardiomyopathy, sudden cardiac death ?	☐Yes/No☐	
High cholesterol (Hyperlipidemia)	☐Yes/No☐	
Metabolic problems (diabetes, thyroid)	☐Yes/No☐	
Other	☐Yes/No☐	
Other	☐Yes/No☐	
Other	☐Yes/No☐	

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PERSONAL MEDICAL HISTORY

Do you now have, or have you ever suffered from any of the following?

Issue/Disorder	Yes/No	If yes, please provide details
Dental bridgework/plates	☐Yes/No☐	
Facial pain	☐Yes/No☐	
Allergies	☐Yes/No☐	
Hayfever / allergic rhinitis	☐Yes/No☐	
Sinus trouble	☐Yes/No☐	
Nasal obstruction	☐Yes/No☐	
Frequent or severe nosebleeds	☐Yes/No☐	
Difficulty clearing ears when flying or diving	☐Yes/No☐	
Ruptured eardrum	☐Yes/No☐	
Ear infections	☐Yes/No☐	
Hearing problems or hearing loss	☐Yes/No☐	
Ringing in the ears	☐Yes/No☐	
Dizziness	☐Yes/No☐	
Persistent/chronic cough	☐Yes/No☐	
Shortness of breath or trouble breathing	☐Yes/No☐	
Wheezing / Asthma	☐Yes/No☐	
Wheezing when breathing cold air/exercising	☐Yes/No☐	
Lung problems requiring inhalers/puffers	☐Yes/No☐	
Bronchitis, pneumonia or pleurisy	☐Yes/No☐	
Tuberculosis	☐Yes/No☐	
Pneumothroax (collapsed lung)	☐Yes/No☐	
Heart trouble or chest pain	☐Yes/No☐	
Irregular / pounding heartbeat	☐Yes/No☐	
High or Low blood pressure	☐Yes/No☐	
Blood vessel or circulation issues	☐Yes/No☐	
Anemia, blood disorder, bleeding problems	☐Yes/No☐	
Sea or motion sickness	☐Yes/No☐	
Frequent heartburn or indegestion	☐Yes/No☐	
Peptic (gastric or duodenal) ulcer	☐Yes/No☐	
Hiatus Hernia	☐Yes/No☐	
Frequent diarrhea	☐Yes/No☐	
Blood mucus in stool	☐Yes/No☐	

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PERSONAL MEDICAL HISTORY

Do you now have, or have you ever suffered from any of the following?

Issue/Disorder	Yes/No	If yes, please provide details
Inflammatory bowel disease	☐ Yes/No ☐	
Jaundice or hepatitis	☐ Yes/No ☐	
Thyroid or glandular trouble	☐ Yes/No ☐	
Kidney disease (including kidney stones)	☐ Yes/No ☐	
Broken bones/dislocated joints	☐ Yes/No ☐	
Rheumatism, arthritis, gout	☐ Yes/No ☐	
Back injury or disease	☐ Yes/No ☐	
Hernia (inguinal or umbilical)	☐ Yes/No ☐	
Severe or frequent headaches	☐ Yes/No ☐	
Migranes	☐ Yes/No ☐	
Head injury or concussion	☐ Yes/No ☐	
Fainting spells, blackouts	☐ Yes/No ☐	
Convulsions, fits, seizures or epilepsy	☐ Yes/No ☐	
Muscle weakness, numbness, tingling	☐ Yes/No ☐	
Neurological disease	☐ Yes/No ☐	
Eye disease, injury, surgery, visual issues	☐ Yes/No ☐	
Colour blindness	☐ Yes/No ☐	
Skin trouble	☐ Yes/No ☐	
Insomnia, nightmares, sleepwalking	☐ Yes/No ☐	
Nervous breakdown	☐ Yes/No ☐	
Depression, mania, bipolar disorder	☐ Yes/No ☐	
Marked anxiety or panic attacks	☐ Yes/No ☐	
Claustrophobia	☐ Yes/No ☐	
Fear of open spaces or heights	☐ Yes/No ☐	
Alcohol or street drug problems	☐ Yes/No ☐	
Heat or cold related illness	☐ Yes/No ☐	
Altitude illness	☐ Yes/No ☐	
Other serious injury, illness or disease	☐ Yes/No ☐	
Have you ever been hospitalized	☐ Yes/No ☐	
Have you ever had surgery	☐ Yes/No ☐	
Have you ever been refused or left employment for medical reasons?	☐ Yes/No ☐	

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PERSONAL MEDICAL HISTORY

Do you now have, or have you ever suffered from any of the following?

Issue/Disorder	Yes/No	If yes, please provide details
Are you currently seeing a doctor for any reason?	☐ Yes/No ☐	
Could you be pregnant?	☐ Yes/No ☐	

PERSONAL HISTORY

What non diving related physically active recreational pursuits do you participate in?

Do you now, or did you in the past year	Yes/No	If yes, give details including what, when, how much, how often and whether you used them between dives.
Smoke?	☐ Yes/No ☐	
Drink Alcohol?	☐ Yes/No ☐	
Take medication prescribed by a doctor	☐ Yes/No ☐	
Take over the counter medication	☐ Yes/No ☐	
Use street drugs	☐ Yes/No ☐	

DIVERS DECLARATION

1. I declare that the contents of this form are accurate with regard to my history and present condition.

2. I authorize the release and exchange of relevant medical information between my family doctor, any examining doctors, and the provincial OHS authority for the purpose of determining my medical fitness to dive.

3. I authorize the release of this examination and classification of my medical fitness to dive to the provincial OHS authority.

Candidate Name:	Date:	Candidate Signature:

COMMENTS (doctors use only)

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PHYSICAL EXAM				Month	Day	Year

General	Height (M)		Weight	
	Body Type		Obesity	
	Immunization Status		Other	
Vision	Visual Acuity – Distance - Uncorrected	Right	Left	
	Visual Acuity – Distance - Corrected	Right	Left	
	Visual Acuity – Near - Uncorrected	Right	Left	
	Visual Acuity – Near - Corrected	Right	Left	
	If corrected, please specify eyewear used when diving.			
	☐ Magnifying Lens	☐ Contact Lenses	☐ Prescription Lens Mask	
Eyes	Pupils			
	Fundi			
Ears	Canals	Right	Left	
	Drums	Right	Left	
	Movement of Drums with Valsalva Manoeuvre	Right	Left	
Nose	Obstruction			
	Mucous Membranes			
Mouth	Teeth and Oral Hygiene			
	Dentures (Partial or Complete)			
CVS	Pulse / Heart Rate		Blood Pressure	
	Heart Size			
	Heart Sounds			
	Murmurs (Description)			
	Bruits			
	Peripheral Circulation (Hands and Feet)			
Chest	Inspection			
	Palpation			
	Percussion			
	Auscultation			
Abdomen	Palpation			
	Hernia Orifices			
Skin & Scars				

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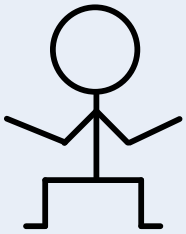
PHYSICAL EXAM				
Musculoskeletal	Spine			
	Upper Limbs, including hands (dexterity)			
	Lower Limbs, including feet			
	Range Of Motion			
	Abnormalities			
Neurological	Cranial Nerves			
	Sensation			
	Tone and Power			
	Romberg			
	Tremor			
	Gait			
	Reflexes (0 = Absent, 1 = Diminished, 2 = Normal, 3 = Brisk, 4 = Very Brisk)			
	Biceps	Right	Left	
	Triceps	Right	Left	
	Radial	Right	Left	
	Knee	Right	Left	
	Ankle	Right	Left	
	Plantar	Right	Left	
Mental Status	Affect			
	Any Contraindication to Diving	☐ No	☐ Yes	
	If yes, comments			
Notes				

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RESULTS OF REQUIRED INVESTIGATIONS

Bloodwork	CBC (Hemoglobin, WBC, Platelets)								
Urinalysis	Blood			Glucose			Protein		
X-Rays	Chest	Skeletal		Shoulders		Right		Left	
				Hips		Right		Left	
				Knees		Right		Left	
ECG	Resting				Exercise				
Spirometry	FEV1		FVC		FEV1/FVC		FEF25-75%		
Audiogram	Hz	250	500	1000	2000	3000	4000	6000	8000
	Right								
	Left								
Other Investigation or Consultations as clinically indicated									

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Diver Certification BOARD OF CANADA

OCCUPATIONAL DIVER'S CERTIFICATE OF MEDICAL FITNESS

This certificate of medical fitness is granted as a result of having passed a comprehensive occupational diver's medical fitness examination conducted by a physician knowledgeable and competent in diving medicine.

DIVER INFORMATION

Diver's Last Name (please print)	First Name(s)	Social Insurance Number	Date of Birth (dd/month/yyyy)

Mailing Address	City	Postal

Last Name: Exam Date: Mo

Phone Number	Email Address

OCCUPATIONAL DIVER'S MEDICAL FITNESS EXAMINATION RESULTS

Classification

☐ Fit ☐ Unfit ☐ Fit with restrictions (specify restrictions)

Date of examination (day/month/year)	Date of medical certification (day/month/year)

Expiry date of medical fitness certificate (must be renewed at least every 2 years up to age 39 years and annually from age 40 onwards or MORE FREQUENTLY IF CLINICALLY INDICATED)

☐ 2 years from date of examination ☐ 1 year from date of examination ☐ Other (Specify expiry date (dd/month/yyyy)

Physician's name (please print clearly)	Physician's Signature
Dr. Suneel Upadhye	

Mailing Address	City		Postal Code
1380 Speers Road, Unit 10	Oakville	Ontario	L6L 5V3

	Business Phone Number
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