

## AS/NZS 2299.1 Supplement 1:2007

### Occupational diving operations

#### **Part 1: Standard operational practice Supplement 1: AS/NZS 2299 diving medical examination forms (Supplement to AS/NZS 2299.1:2007)**



This Supplement is a copy of material from Appendix N of AS/NZS 2299.1:2007.

### **AS/NZS 2299.1 Supp 1:2007**

This Joint Australian/New Zealand Standard Supplement was prepared by Joint Technical Committee SF-017, Occupational Diving. It was approved on behalf of the Council of Standards Australia on 12 July 2007 and on behalf of the Council of Standards New Zealand on 3 August 2007.

This Supplement was published on 20 September 2007.

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The following are represented on Committee SF-017:

Association of Diving Contractors, New Zealand  
Australian Council of Trade Unions  
Australian Diver Accreditation Scheme  
Australian Diving Contractors Association  
Australian Industry Group  
Australian Marine Sciences Association Inc  
Australian Medical Association  
Australian Seafood Industry Council  
CSIRO Marine and Atmospheric Research  
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Dive Queensland  
Hyperbaric Engineering Industry Forum  
Maritime Union of Australia  
NSW Police Service  
National Association of Occupational Diver Training Establishments, Australia  
New Zealand Commercial Diver Training Council  
New Zealand Underwater Association  
Professional Divers Association of Australia  
Royal New Zealand Navy  
South Pacific Underwater Medicine Society  
Underwater Visual Producers Association, Australia  
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### **Keeping Standards up-to-date**

Standards are living documents which reflect progress in science, technology and systems. To maintain their currency, all Standards are periodically reviewed, and new editions are published. Between editions, amendments may be issued. Standards may also be withdrawn. It is important that readers assure themselves they are using a current Standard, which should include any amendments which may have been published since the Standard was purchased.

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Alternatively, both organizations publish an annual printed Catalogue with full details of all current Standards. For more frequent listings or notification of revisions, amendments and withdrawals, Standards Australia and Standards New Zealand offer a number of update options. For information about these services, users should contact their respective national Standards organization.

We also welcome suggestions for improvement in our Standards, and especially encourage readers to notify us immediately of any apparent inaccuracies or ambiguities. Please address your comments to the Chief Executive of either Standards Australia or Standards New Zealand at the address shown on the back cover.

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## AS/NZS 2299 Diving Medical Examination—Medical Questionnaire

**Please complete the following:**

Surname		Given names		
Address				
Date of birth	Sex	M	F	
Phone (home)	Phone (work)	Phone (mobile)		
Occupation				
Most recent dive medical date				
Type of Medical		Limited Occupational Diving—specify type .....		
Unrestricted—including saturation		Recreational Diving Industry work only		
Unrestricted—not including saturation				
Do you participate in any regular physical activity?		Rarely	<1/week	Weekly
Type of physical activity:		2–3/week	Most days	
How many cigarettes do you smoke per day?		Have you been a smoker in the past? Yes No		
Do you drink alcohol?		Yes	No	How many drinks per week (average)?
Do you take any tablets, medicines or drugs?		Yes	No	
List:				
Do you have any allergies?		Yes	No	
List:				
Have you ever had any reactions to drugs, medicines or foods?		Yes	No	
List:				
Next of kin name		Relationship		
Address				
Phone number(s)				

<p><b>Have you ever had, or do you now have or suffer from any of the following:</b></p> <p>Prescription spectacles..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contact lenses ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye or visual problem ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dentures or plate..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent dental procedure..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinusitis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nosebleeds ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Deafness or ringing noises in the ear..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ear infections or discharge from the ear..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Giddiness or loss of balance..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Operation on the ear..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other ear, nose or throat problem..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Severe motion sickness..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Need to take seasickness medication..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with ears or sinuses when flying in aircraft <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Severe or frequent headaches..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Migraine..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting or blackouts ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Convulsions, fits or epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unconsciousness ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Head injury or concussion..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sleepwalking..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Severe depression..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Claustrophobia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mental illness ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Abnormal blood test..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ECG..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Palpitations or consciousness of your heartbeat.... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High blood pressure ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain or discomfort in the chest on exertion..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of breath on exertion ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bronchitis or pneumonia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pleurisy or severe chest pain ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Doctor's use only</p>
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		Candidate's name .....
		Doctor's use only
Coughing up blood or phlegm .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic or persistent cough .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
TB .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumothorax .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent chest colds or flu .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma or wheezing .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Need to use a puffer or inhaler .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Operation on chest, lungs or heart .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other chest complaint .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Indigestion, acid reflux or peptic ulcer .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vomiting blood or passing red or black bowel motions .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent vomiting or diarrhoea .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Jaundice, hepatitis or liver disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Malaria or other tropical disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severe loss of weight .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hernia or rupture .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Back injury .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Significant joint problem or sports injury .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Limitation of movement .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fracture .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Paralysis or muscle weakness .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney or bladder disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sickle cell disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding problem or other blood disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Contagious disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Operations .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
List operations		
<b><u>Females only</u></b>		
Are you now pregnant or planning to be .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have periods which incapacitate you or which may reduce your physical or mental performance ...	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><u>Other medical history</u></b>		
Admitted to hospital .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rejected for life insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Failed a medical examination .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Unable to work on medical grounds .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other illness or health problem .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><u>Family history</u></b>		
Family history of heart disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family history of asthma or chest disease .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><u>Diving history to date</u></b>		
Approx. date of first compressed air dive .....		
Total hours under pressure .....		
Types of diving experience:		
<input type="checkbox"/> Scuba air	<input type="checkbox"/> Surface supply	
<input type="checkbox"/> Scuba mix gas	<input type="checkbox"/> Surface deco	<input type="checkbox"/> Oxygen
<input type="checkbox"/> Hookah	<input type="checkbox"/> Bell diving	
How many dives to date .....		
Longest dive .....		
Deepest dive .....		
Have you ever suffered from—		
ear squeeze? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
sinus squeeze? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
decompression illness? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
headaches during or after dive? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
extreme tiredness after dive? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other diving-related problems? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify .....		

I hereby authorize the examining doctor to obtain or supply medical information regarding me from or to other doctors as may be necessary for medical purposes in my personal interest.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Candidate's name.....

**AS/NZS 2299 Medical Examination—Findings of Examination by Doctor  
Trained in Underwater Medicine**

<b>General appearance</b>
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<b>Visual acuity</b>	<b>Uncorrected</b>	<b>Corrected</b>	<b>Near vision</b>	<b>Colour perception</b>	<b>Height</b>	<b>Weight</b>
Right	6/	6/			cm	kg
Left	6/	6/				
<b>BP</b>	<b>/</b>	<b>Pulse</b>	<b>/min</b>	<b>Urinalysis</b>		

	<b>Notes &amp; Comments</b>
Head, Scalp, Face, Neck .....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Ophthalmoscopy.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Pupils.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eye movements.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Visual fields.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Nose, Septum, Airway, Sinuses	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mouth, Throat, Teeth, Speech	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Ears—external.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Tympanic membrane R.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
L.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eustachian tubes R.....	<input type="checkbox"/> Easily with Valsalva <input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/Unsatisfactory
(ear clearing) L.....	<input type="checkbox"/> Easily with Valsalva <input type="checkbox"/> With difficulty/alternate manoeuvres <input type="checkbox"/> Nil/Unsatisfactory
Chest & lung fields.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Cardiac auscultation.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Abdomen.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Lymph nodes.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Posture & gait.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Spine.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Upper limbs.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Lower limbs.....	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Peripheral pulses.....	<input type="checkbox"/> Right Dorsalis Pedis <input type="checkbox"/> Left Dorsalis Pedis <input type="checkbox"/> Right Post Tibial <input type="checkbox"/> Left Post Tibial

<b>Tendon reflexes</b>		<b>Absent</b>	<b>Weak</b>	<b>Mid-range</b>	<b>Brisk</b>	<b>Hyperreflexic</b>	<b>Notes &amp; Comments</b>
Biceps	R	_____					
	L	_____					
Triceps	R	_____					
	L	_____					
B/Rad	R	_____					
	L	_____					
Knee	R	_____					
	L	_____					
Ankle	R	_____					
	L	_____					

(mark line to indicate strength of reflex elicited)

*(continued)* Page 3 of 4

Candidate's name.....

Plantar reflexes Right..... Left.....

Sensation.....  Normal  Abnormal

Cerebellar functions.....  Normal  Abnormal

Sharpened Romberg test	Time stable.....(s) <input type="checkbox"/> Very stable	<input type="checkbox"/> Major swaying/wobbles
	<input type="checkbox"/> A few minor sways/wobbles	<input type="checkbox"/> Unable to hold balance
	No. of attempts .....	<input type="checkbox"/> Moderately unsteady

Emotional & psychiatric stability  Normal  Abnormal

Exercise tolerance.....  Fitness good—History  
 Fitness acceptable—History  
 Exercise test requested  
 Exercise test performed (specify type & result)

Chest X-Ray.....  Normal  Abnormal Date..... Place.....

Lung function.....  Normal  Abnormal

Vital capacity.....

FEV<sub>1</sub>.....

Percentage.....

**Audiometry**

Hearing level	Frequency, Hz							
	500	1000	1500	2000	3000	4000	6000	8000
dB (R)								
dB (L)								

Tympanometry.....  Normal  Abnormal  Pending

Long Bone Survey.....  Not indicated  Recommended

Other tests.....  Nil required  Indicated (specify)

Other abnormalities.....  Nil noted  Noted (specify)

NOTES:

**AS/NZS 2299  
Occupational Diver Medical Fitness Certificate**

I, \_\_\_\_\_, certify that  
(Doctor's name)

\_\_\_\_\_  
(Candidate's name)

has been assessed for medical fitness to dive in accordance with AS/NZS 2299.1:2007 and has been found—

- Fit to dive/work under pressure
- Permanently unfit
- Temporarily unfit—Review date.....
- Decision pending .....

**Categories of diving for which fitness was assessed:**

- All occupational diving
- All except saturation
- Other.....

**Advice provided:**

**Comments:**

I confirm that I have received formal training in the conduct of occupational diving medical examinations.

**Signed**.....

**Doctor's name (print)**.....

**Date** .....

Candidate's signature.....