Participant Name (Print) | **Birthdate** Date (DD/MM/YY)

Freediver Medical | Participant Questionnaire

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

Directions

Complete this questionnaire as a prerequisite to an SSI recreational freediving program.

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

1	I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes Go to box A	No
2	I have a personal or family history of respiratory or cardiac disease.	Yes Go to box B	No
3	I struggle to perform moderate exercise (for example, walk 1.6 kilometers/one mile in 14 minutes or swim 100 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 or developmental 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

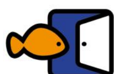
Participant Signature

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/YY)
Participant Name (Print)	Date of Birth (DD/MM/YY)
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.



Participant Name (Print)

Birthdate Date (DD/MM/YY)

Freediver Medical | Participant Questionnaire (Continued)

BOX A – I have/have had:		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.	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
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes *	No

BOX B – I have/have a family history of:		
Smoking or tobacco use.	Yes *	No
High cholesterol levels.	Yes *	No
High blood pressure.	Yes *	No
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

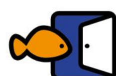
BOX D – I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes *	No
Persistent neurologic injury or disease.	Yes *	No
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes *	No
Blackouts or fainting (full/partial loss of consciousness) 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 or special accommodation.	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, either 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).



SSI Training Center #714166
het Duikhuis Rotterdam
Admiraal de Ruyterweg 40A, 3031 AD Rotterdam
NETHERLANDS
info@hetduikhuis.nl I Tel: +31 85 4017194

Participant Name (Print) | **Birthdate** Date (DD/MM/YY)

Freediver Medical | Medical Examiner's Evaluation Form

The above-named person requests your opinion of his/her medical suitability to participate in recreational freediving training or activities. 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 freediving.

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

Signature of certified medical doctor or other legally certified medical provider | Date (DD/MM/YY)

Medical Examiner's Name

(Print)

Clinical Degrees/Credentials

Clinic/Hospital

Address

Phone

Email

Physician/Clinic Stamp (optional)