



## MEDICAL GUIDELINES AND RECOMMENDATIONS

### INTRODUCTION

The following recommendations are set forth by the ADCI and are intended to be used with the ADCI medical history/physical examination forms. They deal with specific aspects of the subject's physical fitness to dive by item number. These standards are offered with what we believe, in most cases, to be the minimum requirements. The use of these standards is intended to be tempered with the good judgment of the examining physician. Where there is doubt about the medical fitness of the subject, the examining physician should seek the further opinion and recommendations of an appropriate specialist in that field. Particular attention must be paid to past medical and diving history. In general, a high standard of physical and mental health is required for diving. Consequently, in addition to excluding major disqualifying medical conditions, examining physicians should identify and give careful consideration to minor, chronic, recurring or temporary mental or physical illnesses that may distract the diver and cause him or her to ignore factors concerned with his or her own safety or others' safety.

It is recommended that the medical examination be performed by a physician that has completed formal training or has experience in the medical assessment of fitness for commercial diving. Examinations shall not be performed by non-physicians.

The spectrum of commercial diving includes industrial tasks performed from just below the surface to deep saturation diving. Job descriptions and therefore job-limiting disabilities may vary widely. These standards, in general, apply to all divers. Some consideration must be given to the subject's medical history, work history, age, etc. Within commercial diving it may be that a diver is fit to perform some jobs but not others.

There is no minimum or maximum age limit, providing all the medical standards can be met. The ADCI does not issue commercial diver certification cards to persons younger than 18 years of age. Serious consideration must be given to the need for all divers to have adequate reserves of pulmonary and cardiovascular fitness for use in an emergency. The lack of these reserves may possibly lead to the termination of a professional diving career. The examining physician should exercise the appropriate professional judgment to determine whether in particular circumstances additional testing may be warranted. Disqualification for an inability to meet any of these standards must be determined on a case-by-case basis.

Upon application by a company or individual, and with concurrence by the examining physician, particular medical circumstances may justify that a temporary variance be granted. Examining physicians must be familiar with the essential job functions (job description) for each commercial diving physical examination. The examining physician is encouraged to make any recommendations for reasonable accommodations necessary for a person to meet these standards.

The numbered items within these standards refer to boxes on the ADCI medical history/physical examination form. These forms are available for download on the ADCI website.

If any further clarification of this recommended standard is desired, please contact the ADCI.



**ADCI PHYSICAL EXAMINATION STANDARDS**

Patient history is recorded on pages 2-15 through 2-16 of the form set. Pages 2-17 and 2-18 are used to record specific findings during the conduct of the examination.

The following headings refer to and explain the numbered boxes on the **ADCI physical examination form** on pages 2-17 and 2-18. A sample copy of these forms is enclosed in this standard. Use of these forms ensures quality and consistency throughout the commercial diving industry. These forms may be obtained from the ADCI website.

1	<b>Name</b>	Record.
2	<b>Social Security Number or Passport Number</b>	Record.
3	<b>Height</b>	No set limits.
4	<b>Weight</b>	The weight limits listed in the maximum allowable weight chart (2.4.9) should apply. If a diver exceeds these limits and the cognizant physician feels the increase is due to muscular build and physical fitness, a variance may be appropriate. A variance may be appropriate for divers who do not meet the weight limits but are at 23% body fat or less as measured by impedance or hydrostatic fat testing. Furthermore, individuals who fall within these weight limits but who present an excess of fatty tissue should be disqualified.
5	<b>Body Fat</b>	Optional. According to US Navy, 23% for males, 34% for females.
6	<b>Body Mass Index (BMI)</b>	Optional. Calculation for BMI = $(\text{weight in pounds} \times 703) / \text{height in inches}^2$ . The maximum BMI allowable according to the U.S. Navy height and weight table is 28.
7	<b>Temperature</b>	The diver should be free of any infection/disease that would cause an abnormal temperature.
8	<b>Blood Pressure</b>	The resting blood pressure should not exceed 140/90 mm Hg. In cases of apparent hypertension, repeated daily blood pressure determinations should be made before a final decision is made. The blood pressure should be controlled without target organ damage. Beta blockers are not acceptable. Low-dose diuretics are acceptable. Medications required to control blood pressure should be noted on the physical exam form.
9	<b>Pulse/Rhythm</b>	Persistent tachycardia, arrhythmia except of the sinus type, or other significant disturbance of the heart or vascular system should be evaluated and may be disqualifying.
10	<b>General Appearance/ Hygiene</b>	Should be good.
11	<b>Distant Vision</b>	Vision must be tested with and without correction when applicable. Should have vision corrected to 20/40, in both eyes. Monocular vision is not necessarily disqualifying for commercial diving. Divers who have had vision corrective surgery should be restricted from diving until cleared by a qualified diving physician and ophthalmologist.
12	<b>Near Vision</b>	Correctable to 20/40.
13	<b>Color Vision</b>	Record. Color blindness does not disqualify for diving, but diver must have color vision specific for duties.
14	<b>Field of Vision</b>	Should be normal, with any discrepancies documented. A minimum of 85 degrees field of vision is required.
15	<b>Contact Lenses</b>	Record if used. Appropriate lenses for diving may be used (gas permeable/fenestrated hard lens). Vision must be recorded with and without contact lenses.
16	<b>Head, Face and Scalp</b>	Some causes for rejection may include: <ul style="list-style-type: none"> <li>a) Deformities of the skull in the nature of depressions, exostosis, etc., of a degree that would prevent the individual from wearing required equipment.</li> <li>b) Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord or peripheral nerves.</li> <li>c) Loss or congenital absence of the bony substance of the skull.</li> </ul>



17	Neck	<p>Conditions affecting the neck must not impair the diver to cause insufficient range of motion. The causes for rejection may include:</p> <ul style="list-style-type: none"> <li>a) Cervical ribs if symptomatic.</li> <li>b) Congenital cysts of bronchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.</li> <li>c) Fistula, chronic draining, of any type.</li> <li>d) Spastic contraction of the muscles of the neck of a persistent and chronic nature.</li> <li>e) Neural impingement.</li> </ul>
18	Eyes	<p>Active pathology or previous eye surgery may be cause for restriction or rejection. Divers who have had vision corrective surgery should be restricted from diving until cleared by a qualified diving physician and ophthalmologist. History of cataract surgery with intraocular lens implant is not disqualifying.</p>
19	Fundus	<p>Optional. No pathology.</p>
20	Through # 24	<p>The following conditions are disqualifying:</p> <ul style="list-style-type: none"> <li>a) Acute disease including vestibular disease.</li> <li>b) Chronic serious otitis.</li> <li>c) Active otitis media.</li> <li>d) Current perforation of the tympanic membrane.</li> <li>e) PE tubes in place.</li> <li>f) Any significant nasal or pharyngeal respiratory obstruction.</li> <li>g) Chronic sinusitis if not readily controlled.</li> <li>h) Speech impediments due to organic defects.</li> <li>i) Inability to equalize pressure due to any cause.</li> <li>j) Recurrent or persistent vertigo.</li> <li>k) Recent piercings are disqualifying until healed.</li> </ul> <p>If Eustachian tube dysfunction is suspected, then referral or testing should be done. Adequately repaired round window ruptures that have no significant residual deficits may be approved for diving.</p>
25	Mouth and Throat	<ul style="list-style-type: none"> <li>a) Candidate should have a high degree of dental fitness; any abnormalities of dentition or malformation of the mandible likely to impair the diver's ability to securely and easily retain any standard equipment mouthpiece should disqualify.</li> <li>b) Removable dentures should not be worn while diving.</li> <li>c) Severe dental caries is disqualifying until repaired.</li> </ul>
26	Chest (include breasts)	<p>Note any chest deformities, breast abnormalities or masses.</p>
27	Lungs	<p>Pulmonary: Congenital and acquired defects that may restrict pulmonary function, cause air entrapment, or affect the ventilation-perfusion or balance shall be disqualifying for both initial training and continuation. Obstructive or restrictive pulmonary functions require further evaluation. Pulmonary disease requiring medication use may be disqualifying. History of recurrent or spontaneous pneumothorax is disqualifying.</p>
28	Heart (thrust, size, rhythm, sounds)	<p>Any evidence of heart disease or arrhythmias other than sinus arrhythmias must be fully investigated. For evaluation purposes, Bruce protocol functional stress testing through stage III must be to at least 10 METS without evidence of ischemia. Pacemakers and implantable cardiac defibrillators are disqualifying. PFO repairs are not disqualifying. Routine PFO testing is not recommended. Coumadin or any anticoagulants, antiplatelet medications and aspirin (except low dose aspirin) are considered disqualifying. Ejection fractions must be at least 40% if measured.</p>
29	Pulse	<p>Record. Peripheral pulses should be regular, full and symmetric.</p>



30	<b>Vascular System (varicosities, etc.)</b>	Cardiovascular system: The cardiovascular system shall be without significant abnormality in all respects as determined by physical examination and tests as may be indicated. Evidence of symptomatic arteriosclerosis, severe varicose veins and marked symptomatic hemorrhoids may be disqualifying.
31	<b>Abdomen and Viscera</b>	<ul style="list-style-type: none"> <li>a) Active peptic ulceration should be disqualifying until treated and healing has been documented. History of gastrointestinal bleeding may be disqualifying from diving and is disqualifying from saturation diving.</li> <li>b) Any other chronic gastrointestinal disease (e.g., ulcerative colitis, cholelithiasis) may be cause for rejection.</li> <li>c) Crohn's disease may be disqualifying.</li> <li>d) Hepatitis may be disqualifying.</li> <li>e) Colostomies should be disqualified for saturation diving.</li> </ul>
32	<b>Hernia (all types)</b>	All inguinal or femoral hernias are disqualifying until repaired. Ventral hernias more than one cm must be repaired prior to diving.
33	<b>Endocrine System</b>	Diabetics controlled only with diet and exercise and with Hgb A1C < 7.0 are acceptable. History of thyroid disease adequately controlled with medication is acceptable to dive. Any other endocrine disorders requiring medication may be disqualifying.
34	<b>G-U System (genital-urinary)</b>	<ul style="list-style-type: none"> <li>a) Gonococcal disease, syphilis, chlamydia and genital herpes will disqualify until adequately treated.</li> <li>b) Evidence or history of nephrolithiasis must be fully investigated and treated and may be disqualifying.</li> <li>c) Any renal insufficiency or chronic renal disease may be disqualifying.</li> <li>d) History of kidney stones may be disqualifying for surface and saturation diving. Divers with a history of kidney stones should have periodic evaluation by a urologist to determine the presence of stones.</li> <li>e) Evidence or history of urinary dysfunction or retention must be fully investigated and treated.</li> </ul>
35	<b>Upper Extremities (strength, ROM)</b>	Any impairment of musculoskeletal function should be carefully assessed against the general requirements that would interfere with the individual's performance as a diver. Amputations may be disqualifying. Orthopedic internal fixation hardware is not disqualifying if the fracture site is healed.
36	<b>Lower Extremities, Except Feet</b>	Any impairment of musculoskeletal function should be carefully assessed against the general requirements that would interfere with the individual's performance as a diver. Amputations may be disqualifying. Orthopedic internal fixation hardware is not disqualifying if the fracture site is healed.
37	<b>Feet</b>	Any impairment of musculoskeletal function should be carefully assessed against the general requirements that would interfere with the individual's performance as a diver.
38	<b>Spine</b>	Any impairment of musculoskeletal function should be carefully assessed against the general requirements that would interfere with the individual's performance as a diver. Neural impingement or nerve root displacement is considered disqualifying even if asymptomatic.
39	<b>Skin and Lymphatic System</b>	Active, acute or chronic disease of the skin or lymphatic system may be disqualifying. Tattoos must be fully healed prior to diving.
40	<b>Anus and Rectum</b>	Any conditions that interfere with normal function (e.g., stricture, prolapse, severe hemorrhoids) may be disqualifying.
41	<b>Sphincter Tone</b>	Note and record.
	<b>Neurological Exam (42-49)</b>	A full examination of the central and peripheral nervous system should show normal function, but localized minor abnormalities, such as patches of anesthesia, are allowable provided generalized nervous system disease can be excluded. Any history of seizure (apart from childhood febrile convulsions, oxygen toxicity or withdrawal seizures) is disqualifying. Intracranial surgery, loss of consciousness, and severe head injury involving more than momentary unconsciousness or concussion, may be disqualifying. If the severity of head injury is in doubt, special consultation and studies should be considered. All neurodegenerative conditions are disqualifying.



42	<b>Cranial Nerves</b>	Examine, evaluate and record.
43	<b>Reflexes</b>	Should be symmetrical and free from pathology. Document any abnormalities. Pathological reflexes should be evaluated. Asymmetrical reflexes should be documented.
44	<b>Cerebellar Function</b>	Test and record.
45	<b>Strength and Tone of Muscles</b>	Examine and record. Note any atrophy or loss of tone.
46	<b>Proprioception/ Stereognosis</b>	Examine and record.
47	<b>Nystagmus</b>	Do and record. Congenital nystagmus is not necessarily disqualifying. End point lateral gaze nystagmus is considered normal.
48	<b>Sensations and Vibration</b>	Test and record. Vibration should be tested using a 128 Hz tuning fork. Two point discrimination should be tested at the thumb (C6), middle finger (C7) and the little finger (C8) and should be discernable at 5 mm.
49	<b>Romberg</b>	Do and record. May perform romberg for up to two minutes.
50	<b>Miscellaneous Remarks and Dermatome Diagram</b>	Record findings and comments.
51	<b>Urinalysis</b>	Includes color pH, specific gravity, glucose, albumin and micro, and all results should be within normal limits.
52	<b>Blood Tests</b>	Hematology: Any significant anemia or history of hemolytic disease must be evaluated. When due to a variant hemoglobin state, it shall be disqualifying.
53	<b>Spirometry</b>	All divers must have periodic spirometry to establish Forced Expiratory Volume at one (1) second (FEV1), Forced Vital Capacity (FVC) , and FEF 25-75 recording best of three measurements using American Thoracic Society standards. FEV1 and FVC should both be 75% or over using NHANES reference values. If either or both are below 75%, then the diver should be referred for functional stress testing under Bruce protocol to at least 10 METS.
54	<b>X-ray/Imaging</b>	<ul style="list-style-type: none"> <li>a) 14 x 17 chest: PA and lateral every three years. No pathology within normal limits.</li> <li>b) Lumbar/sacral spine (optional on new hire).</li> <li>c) Long bones (optional): Any lesions, especially juxta-articular, should be evaluated to determine patient's fitness to dive.</li> <li>d) MRI (optional): Neural impingement or nerve root displacement on MRI examinations are disqualifying.</li> </ul>
55	<b>Electrocardiogram</b>	ECG examinations: Resting standard 12 lead ECG are optional on new hire examinations and required annually after the age of 35. Exercise stress tests should be considered and may be indicated after the age of 40.
56	<b>Audiogram Pure Tone</b>	A hearing loss in either ear of 40 dB in the range of 500, 1000 and 2000 Hz may be an indication for referral of the candidate to a specialist for further opinion, unless the examining doctor is convinced that such a hearing loss is unlikely to be significantly increased by continued diving activities. Doubts about function of labyrinths require specialized examination. Monaural hearing is not disqualifying. Hearing ability must be adequate to perform job duties.
57	<b>Comprehensive Metabolic Panel</b>	Optional.
58	<b>Hemoglobin A1C</b>	Required for any history of diabetes.
59	<b>Lipid Panel</b>	Required for Framingham Risk Calculation. Must be done on divers 35 years and older.
60	<b>Drug Screen</b>	Recommended.



ADC MEDICAL HISTORY AND EXAMINATION FORMS



Association of Diving Contractors International  
MEDICAL HISTORY FORM

Employer			Job Title			Date			
1. Last Name		First Name	Middle Name	2. Email Address		3. Date of Birth		4. Gender	5. Last 4 No. of SSN
6. Address (Number, Street)			7. City		8. State	9. Zip Code	10. Area Code - Phone Number ( )		
11. Emergency Contact Person - Relationship - Address - Telephone Number							12. Cell Phone Number ( )		

13. MEDICAL HISTORY: Have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Angiogram or ECHO	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	PFO Repair	<input type="checkbox"/>	<input type="checkbox"/>	Elbow Injury
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arm/wrist/hand Injury
<input type="checkbox"/>	<input type="checkbox"/>	Disabling Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Hip/Leg/Ankle Injury
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury or "Trick Knee"
<input type="checkbox"/>	<input type="checkbox"/>	Severe Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble or Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints
<input type="checkbox"/>	<input type="checkbox"/>	Wear Contacts/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones or Fractures
<input type="checkbox"/>	<input type="checkbox"/>	Color Vision Defect	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease or Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease or Stones	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disease or Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Goiter or Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Perforated Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Clearing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding/Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	Anemia: Sickle Cell or Other
<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash or Disease
<input type="checkbox"/>	<input type="checkbox"/>	Airway Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains	<input type="checkbox"/>	<input type="checkbox"/>	Staph Infections
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness/Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Protein, Sugar or Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Any Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Strain or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Prior Military Service
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Stent or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Spine Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness or Injury or Any Other Medical Condition
<input type="checkbox"/>	<input type="checkbox"/>	For Females ONLY	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc or Sciatica			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses			
			<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy			Last Menstrual Period

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

14. LIST ALL SURGERIES \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15. LIST ALL HOSPITALIZATIONS \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

16. LIST ALL INJURIES \_\_\_\_\_ YEAR \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. ANSWER THE FOLLOWING QUESTIONS:  
 Every Item Checked Yes Must Be Fully Explained Below

	YES	NO		YES	NO
Do you have any physical defects or any partial disabilities?			Have you ever resigned, been terminated, or changed jobs for medical reasons?		
Have you ever been rejected or rated for insurance, employment, license, or armed forces for health reasons?			Have you ever been dismissed from employment because of excess use of drugs or alcohol?		
Have you ever had illnesses, injuries, or lost time accidents from any work that you have done?			Do you have any allergies or reactions to food, chemicals, drugs, insect stings, or marine life?		
Have you been advised to have a surgical operation or medical treatment that has not been done?			Are you presently under the care of a physician? Give physician's name and address on the next page.		

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_



19. My Personal Physician is: Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State \_\_\_\_\_  
 Phone Number \_\_\_\_\_

20. DIVING HISTORY How long have you been commercial diving? \_\_\_\_\_

Surface Air Diving History		Saturation Diving History	
Maximum Depth Surface Air _____		Heliox Yes <input type="checkbox"/> No <input type="checkbox"/>	Maximum Depth _____
Maximum Depth Surface Mixed Gas _____		Trimix Yes <input type="checkbox"/> No <input type="checkbox"/>	Maximum Duration (Days) _____
Longest Bottom Time Air _____		Nitrox Yes <input type="checkbox"/> No <input type="checkbox"/>	
Longest Bottom Time Mixed Gas _____			

21. DIVING EXPERIENCE (Number of years experience):

Air \_\_\_\_\_ Name of Diving School \_\_\_\_\_  
 Mixed Gases \_\_\_\_\_  
 Saturation \_\_\_\_\_

22. INDICATE THE NUMBER OF DECOMPRESSION INCIDENTS  
 If None put 0 (Zero) List any residuals

Bends, pain only \_\_\_\_\_  
 Bends, neurological \_\_\_\_\_  
 Chokes \_\_\_\_\_  
 Inner ear \_\_\_\_\_

23. IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)

Yes	No	Details	Yes	No	Details
<input type="checkbox"/>	<input type="checkbox"/>	Gas Embolism _____	<input type="checkbox"/>	<input type="checkbox"/>	Lung Squeeze _____
<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Near Drowning _____
<input type="checkbox"/>	<input type="checkbox"/>	CO <sub>2</sub> Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Asphyxiation _____
<input type="checkbox"/>	<input type="checkbox"/>	CO Toxicity _____	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (Dizziness) _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear/Sinus Squeeze _____	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Drum Rupture _____	<input type="checkbox"/>	<input type="checkbox"/>	Nitrogen Narcosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness _____	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness _____

24. Have you been involved in a diving accident (decompression sickness or others) since your last physical examination?  Yes  No

25. Date of last physical examination: \_\_\_\_\_ Name of Physician who performed your last exam \_\_\_\_\_  
 For what company or organization were you last examined? \_\_\_\_\_ Address of Physician \_\_\_\_\_  
 \_\_\_\_\_ City, State \_\_\_\_\_

26. Have you ever had any of the following? If so, give approximate date:

Yes	No	Give Date	Yes	No	Give Date
<input type="checkbox"/>	<input type="checkbox"/>	Chest X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Function Studies _____
<input type="checkbox"/>	<input type="checkbox"/>	Longbone Series _____	<input type="checkbox"/>	<input type="checkbox"/>	Audiogram _____
<input type="checkbox"/>	<input type="checkbox"/>	Back (Spine) X-Ray _____	<input type="checkbox"/>	<input type="checkbox"/>	EKG _____
<input type="checkbox"/>	<input type="checkbox"/>	MRI _____	<input type="checkbox"/>	<input type="checkbox"/>	Exercise (Stress) EKG _____

27. Physician Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

\_\_\_\_\_  
 Date Signature



**Association of Diving Contractors International  
PHYSICAL EXAMINATION FORM**

Employer		Date		Date of Birth		Age			
1. Last Name First Name Middle Name				2. Last 4 No. of SSN or PASSPORT No.					
3. Height (inches)		4. Weight (pounds)		5. Body Fat (%) (Optional)		6. BMI (Optional)			
7. Temperature		8. Blood Pressure /		9. Pulse/Rhythm		10. General Appearance/Hygiene		11. Build	
12. Distant Vision: R. 20/_____ Corr. to 20/_____ L. 20/_____ Corr. to 20/_____				13. Near Vision: Jaeger R. 20/_____ Near Vision Corrected L. 20/_____ R. 20/_____ L. 20/_____		14. Color Vision (Test Performed and Results)			
15. Field of Vision (Degrees) R _____ ° L _____ °				16. Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No					
NORMAL		ABNORMAL		Check each item in appropriate column (enter NE for Not Evaluated)				REMARKS	
				17. Head, Face, Scalp					
				18. Neck					
				19. Eyes					
				20. Ears – General (internal and external canal)					
				21. Eustachian Tube Function					
				22. Tympanic Membrane					
				23. Nose (Septal Alignment)					
				24. Sinuses					
				25. Mouth and Throat					
				26. Chest					
				27. Lungs					
				28. Heart (Thrust, Size, Rhythm, Sounds)					
				29. Pulses (Equality, etc.)					
				30. Vascular System (Varicosities, etc.)					
				31. Abdomen and Viscera					
				32. Hernia (All Types)					
				33. Endocrine System					
				34. G-U System					
				35. Upper Extremities (Strength, ROM)					
				36. Lower Extremities (Except Feet)					
				37. Feet					
				38. Spine					
				39. Skin, Lymphatics					
				40. Anus and Rectum					
				41. Sphincter Tone					

**NEUROLOGICAL EXAMINATION**

**42. CRANIAL NERVES**

		NORMAL	ABNORMAL	NE
I	Olfactory			
II	Optic			
III	Oculomotor			
IV	Trochlear			
V	Trigeminal			
VI	Abducens			
VII	Facial			
VIII	Auditory			
IX	Glossopharyngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

**43. REFLEXES**

		DEEP TENDON					PATHOLOGICAL				SUPERFICIAL				
Triceps Biceps Patella Achilles	Left	0	1	2	3	4	Babinski Hoffman Ankle Clonus	Present	Absent	Present	Absent	Upper Abdomen Lower Abdomen Cremasteric	Present	Absent	NE
	Right	0	1	2	3	4									

**44. CEREBELLAR FUNCTION**

	0	1	2	3	4
Ataxia					
Tremor (intention)					
Finger to Nose					
Heel to Shin (Sliding)					
Rapidly Alternating Movements					
	Normal	Abnormal			

**45. MUSCLE**

	STRENGTH					TONE	
	1	2	3	4	5	Normal	Abnormal
Right Upper Extremity							
Left Upper Extremity							
Right Lower Extremity							
Left Lower Extremity							

**46. PROPRIOCEPTION**

	Left		Right	
	Normal	Abnormal	Normal	Abnormal
Joint Position Sense				
Stereognosis				
Vibratory Sensation				

**47. NYSTAGMUS**

	Present	Absent
End Point Lateral Gaze		
Pathological		

**48. SENSATION**

	Normal	Abnormal
Hot		
Cold		

	Normal	Abnormal
Sharp		
Soft		

**49. RHOMBERG**

Two Point Discrimination		Absent	Present
Normal			
Abnormal			





50. MISCELLANEOUS REMARKS

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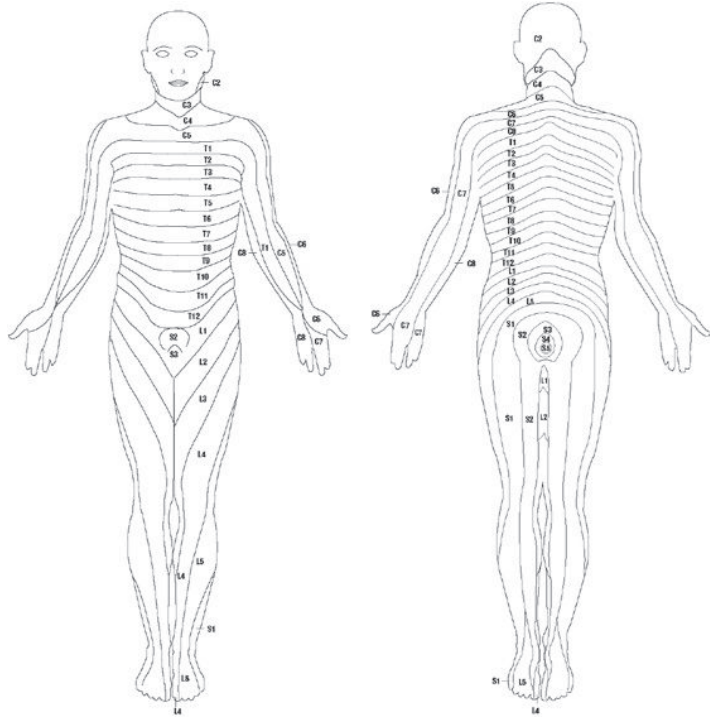
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LABORATORY FINDINGS

<b>51. Urinalysis</b> Color _____ Appearance _____ Sp. Gravity _____ Ph _____ Microscopic Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> (See report)	Sugar Blood Ketones Bilirubin Protein	<table border="1"> <tr> <th>0</th> <th>1+</th> <th>2+</th> <th>3+</th> <th>4+</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	0	1+	2+	3+	4+																<b>52. Blood Tests</b> CBC Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>  Sickle Cell <input type="checkbox"/> Pos <input type="checkbox"/> Neg	Attach Reports RPR <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
		0	1+	2+	3+	4+																			
<table border="1"> <tr> <td colspan="2"><b>53. Cardiac Risk Score</b></td> </tr> <tr> <td>No. of Points</td> <td>_____</td> </tr> <tr> <td>10 year risk</td> <td>_____</td> </tr> </table>	<b>53. Cardiac Risk Score</b>		No. of Points	_____	10 year risk	_____																			
<b>53. Cardiac Risk Score</b>																									
No. of Points	_____																								
10 year risk	_____																								
<b>54. Pulmonary Function</b> FVC _____ FEV1 _____ FEV1/FVC _____	<b>55. X-ray/MRI</b> Chest <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Lumbar Spine <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Long Bones <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal MRI <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	(Describe) _____ _____ _____ _____																							
<b>56. Electrocardiogram</b> Static _____ Exercise Stress _____	<b>57. Audiogram</b> <table border="1"> <tr> <th>Hz</th> <th>500</th> <th>1000</th> <th>2000</th> <th>3000</th> <th>4000</th> <th>6000</th> <th>8000</th> </tr> <tr> <td>Left</td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Right</td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Hz	500	1000	2000	3000	4000	6000	8000	Left								Right							
Hz	500	1000	2000	3000	4000	6000	8000																		
Left																									
Right																									
<b>58. Comprehensive Metabolic Panel</b> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Attach Report <input type="checkbox"/> <b>Lipid Panel (if done)</b> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Comments: _____ _____ _____	<b>59. Drug Screen</b> <input type="checkbox"/> Not collected <input type="checkbox"/> Collected, results sent to employer																						

Work Status:

Fit for diving  
 Cleared for supervisor  
 Cleared for topside work only  
 Cleared with restrictions: \_\_\_\_\_  
 Further evaluation needed: \_\_\_\_\_  
 Unfit for diving : \_\_\_\_\_  
 Unfit

Examinee Name \_\_\_\_\_  
 Physician Signature \_\_\_\_\_  
 Physician Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Date of Examination \_\_\_\_\_

**Comments:** \_\_\_\_\_  
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