

# ABBREVIATED AVIATION MEDICINE EXAMINATION

Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ UIC: \_\_\_\_\_ E-mail POC: \_\_\_\_\_

Purpose of exam: \_\_\_\_\_ if Other: \_\_\_\_\_ Date (dd mmm yyyy): \_\_\_\_\_

A. History: Have you experienced any of the following since your last flight physical?							
Blk	Symptom	YES	NO	Blk	Symptom	YES	NO
1	Injured, hospitalized, or received medical care			15	Significant changes to your appetite, thirst, weight, or temperature sensitivity		
2	Use of any prescription medications, over the counter medications, vitamins, supplements, or performance enhancers			16	Black, bloody, or clay-colored stool If yes, was it associated with hemorrhoids?		
3	Undergone any surgeries, to include eye surgery			17	Abdominal pain or cramps		
4	Any vision changes (difficulty at night, double vision, trouble reading, floaters, inability to wear NVGs)			18	Constipation or diarrhea		
				19	Excessive or abnormal bruising or slow blood clotting		
5	Dizziness, vertigo, or issues with balance			20	Swollen lymph nodes		
6	Numbness, tingling, or loss of sensation in limbs			21	Jaundice or yellowing of the skin		
7	Air, sea, or car sickness			22	Ear or sinus pain		
8	Muscular weakness			23	Any of the following skin abnormalities: changes in size, color, or texture of skin growths, itching, ulceration, or scaling		
9	A seizure or been evaluated for any neurological condition						
10	Any changes to your memory, energy, appetite, or sleep patterns			24	Rapid or irregular heartbeat, palpitations, or visited a cardiologist for any reason		
11	Any symptoms of depressed mood, mood instability, or concerning feelings of irritability/anxiety			25	Flight-related back pain If yes, are you a helicopter aviator or aircrew?		
12	Undergone any counseling or psychiatric evaluation If yes, was this marital or relationship counseling?			26	Flight-related neck pain If yes, do you routinely wear NVG? If yes, do you routinely wear a helmet with a HUD/JHMCS? If yes, are you a helicopter aviator or aircrew?		
13	Suicidal or homicidal thoughts			27	Decompression sickness or diving injuries If yes, did you receive oxygen in a hyperbaric chamber?		
14	Frequent or painful urination, blood or discharge in urine, kidney stones, or genital lesions						
Have you ever experienced any of the following?							
28	Been disqualified from flying			30	Undergone any surgery that required a flight waiver		
29	Been evaluated, diagnosed, or treated for alcohol abuse or dependency If yes, are you on a waiver for flight status?			31	Any significant in-flight pressure fluctuations or been in a flight when the environmental control system malfunctioned?		
If your gender is female, complete questions 32-35.							
32	Could you be or are you currently pregnant?			34	Have you ever miscarried, experienced any menstrual irregularity/pain, or abnormal Pap smear?		
33	Are you currently taking or planning to take fertility medications?			35	Have you ever experienced unexplained breast tenderness, swelling, masses, lumps, or discharge?		

36. Do you use tobacco products of any kind, including but not limited to cigarettes, chewing tobacco, snuff, vaping/e-cigarettes, cigars, and pipe tobacco?      Yes /      No      If yes, please elaborate on frequency: \_\_\_\_\_

37. Are you sexually active with any of the following groups:      Men /      Women /      Both /      Not currently active

38. Are you on a waiver?      Yes /      No      If yes, for what condition? \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_

**PATIENT IDENTIFICATION**

Name: \_\_\_\_\_ DoD ID: \_\_\_\_\_ Age: \_\_\_\_\_ DoB: \_\_\_\_\_  
Last      First      MI

Gender:      M /      F      Rank (Rate): \_\_\_\_\_ Designator/NEC/MOS: \_\_\_\_\_ Service: \_\_\_\_\_ UIC/RUC: \_\_\_\_\_

Phone: \_\_\_\_\_ Patient's Command: \_\_\_\_\_ Aircraft: \_\_\_\_\_ Flight Hours: Total \_\_\_\_\_ Last 6 Months: \_\_\_\_\_

**B. Physical Exam**

39. Sitting Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ 40. Pulse: \_\_\_\_\_ 41. Height: \_\_\_\_\_ 42. Weight: \_\_\_\_\_

43. Tympanic Membrane Exam Tympanic membranes normal pearl-gray color with central concavity and cone of light in anterior inferior quadrant? Yes / No

Positive Valsalva Both Ears (AU)? Yes / Positive Right Ear / Positive Left Ear / Negative Both Ears

44. Does the patient wear corrective lenses? Yes / No If Yes, date\* of last exam by eye professional: \_\_\_\_\_

\*Current eye exam is recommended within the past 2 years.

45. DISTANT VISUAL ACUITY (DVA): SNELLEN AFVT GOODLITE			46. NEAR VISUAL ACUITY (NVA): SNELLEN AFVT SLOAN NOTATION NEARPOINT CARD			47. COLOR VISION ( <i>Test used and result</i> ): PIP NUMBER CORRECT: / 14		
RIGHT	20/	CORR TO 20/	20/	CORR TO 20/			PASS	FAIL
LEFT	20/	CORR TO 20/	20/	CORR TO 20/		CB CVT	PASS	FAIL
BOTH	20/	CORR TO 20/	20/	CORR TO 20/		FALANT	PASS	FAIL
48. HETEROPHORIA ( <i>Specify distance</i> ): ES EX RH LH or: NOTOSP (NOHOSH)						49. INTRAOCULAR PRESSURE: OD OS		
50. DEPTH PERCEPTION: UNCORRECTED / CORRECTED			AFVT: PASS ( <i>at least A – B with no misses</i> ) / FAIL			STEREO BOOKLET ( <i>Titmus or Randot</i> ): PASS ( <i>5-40 arc sec</i> ) / FAIL ( <i>greater than 40 arc sec</i> )		
51. Audiogram	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz		
Right Ear								
Left Ear								

**C. Flight Medicine Provider Comments**

Item #	Comment	CD/NCD	Waiver

**D. Assessment & Disposition Duty Status**

PQ Class I DIACA [SG 1 / 2 / 3] II / III DIF: \_\_\_\_\_ IV \_\_\_\_\_ UAS Group: \_\_\_\_\_

NPQ NAVMED 6150/2 Entry Made Medical Recommendation for Flying Issued (DD 2992)

AA NAA Evaluation Requested For \_\_\_\_\_

Waiver: Recommended / Not Recommended / Pending / Granted (Date) \_\_\_\_\_ Rec. Continue? Yes / No

Waiver Restrictions and Maintenance/Submission Requirements: \_\_\_\_\_

FLIGHT MEDICINE PROVIDER SIGNATURE \_\_\_\_\_ Rank: \_\_\_\_\_ Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT IDENTIFICATION IF NOT SHOWN ON OTHER SIDE

Name: \_\_\_\_\_ Last First MI DoD ID: \_\_\_\_\_