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	☐	☐	26	Flight-related neck pain	☐	☐
	If yes, was this marital or relationship counseling?	☐	☐		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	☐	☐
14	Frequent or painful urination, blood or discharge in urine, kidney stones, or genital lesions	☐	☐		If yes, did you receive oxygen in a hyperbaric chamber?	☐	☐
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	☐	☐	31	Any significant in-flight pressure fluctuations or been in a flight when the environmental control system malfunctioned?	☐	☐
	If yes, are you on a waiver for flight status?	☐	☐				
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: _____ (Last) _____ (First) ____ (MI) **DoD ID:** _____ **Age:** _____ **DoB:** _____

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 *(Test used and result):* ☐ PIP NUMBER CORRECT: / 14 ☐ PASS ☐ FAIL ☐ CB CVT ☐ PASS ☐ FAIL ☐ FALANT ☐ PASS ☐ FAIL
RIGHT	20/	CORR TO 20/	20/	CORR TO 20/	
LEFT	20/	CORR TO 20/	20/	CORR TO 20/	
BOTH	20/	CORR TO 20/	20/	CORR TO 20/	
48. HETEROPHORIA (*Specify distance)*: ES EX RH LH or: ☐ NOTOSP (NOHOSH)					49. INTRAOCULAR PRESSURE: OD OS

50. DEPTH PERCEPTION: ☐ UNCORRECTED / ☐ CORRECTED AFVT: ☐ PASS *(at least A – B with no misses)* / ☐ FAIL STEREO BOOKLET *(Titmus or Randot)*: ☐ PASS *(5-40 arc sec)* / ☐ FAIL *(greater than 40 arc sec)*

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 / ☐ V 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:** _____