ABBREVIATED AEROMEDICAL EXAMINATION

FACILITY: _____ Phone:_____UIC:_____ E-mail POC: _____

Purpose of exam: _____ Date (dd mmm yyyy):_____

A. History Have you had any of the following since your last physical exam?

Blk	Symptom	YES	NO	Blk	Symptom	YES	NO
1	Hospitalized, sick-call visit, injured			26	Abdominal pain, cramps		
2	Medically disqualified for flying			27	Constipation, diarrhea		
3	Used medication, including over the counter			28	Black, white, bloody stool		
4	Surgery (including any eye surgery)			29	Jaundice, hepatitis, yellow skin		
5	Shortness of breath with exercise			30	Significant change appetite, thirst, heat or cold tolerance, weight, handwriting, bruising		
6	High blood pressure			31	Weakness		
7	Rapid or irregular heartbeat			32	Fever, chills, night sweats		
8	Chest pain or pressure			33	Change in size, color, or texture of skin growths; itching, ulceration or scaling		
9	Dizziness or balance problems			34	Swollen lymph nodes		
10	Fainting, loss of consciousness			35	Leg or muscle cramps or pain		
11	Headaches or migraines			36	Joint pain, arthritis, stiffness		
12	Head injury			37	Back or neck pain		
13	Numbness, tingling in limbs			38	Sleeping problems		
14	Air, sea or car sickness			39	Depression, worry, nervousness or anxiety		
15	Decompression sickness, diving injury			40	Irritability, mood swings		
16	Fit or seizure			41	Change in memory, energy or appetite		
17	Hoarseness			42	Suicidal, homicidal thoughts		
18	Allergies, hay fever			43	Psychiatric counseling or evaluation		
19	Hearing loss, ringing in ears			44	Frequent, painful urination or blood in urine, kidney stones		
20	Significant cough, sore throat			45	Change in sex interest/function		
21	Coughed up blood			46	Breast tenderness, swelling, mass, lump, discharge		
22	Difficulty swallowing			47	Genital lesion, discharge, or other symptom		
23	Vision change (difficulty at night, double vision, trouble reading)			48	Pregnancy, miscarriage, menstrual irregularity/pain, contraceptive, abnormal PAP		
24	Asthma, wheezing			49	Have you ever been diagnosed or treated for alcohol abuse or dependence?		
25	Indigestion, heartburn, ulcer			50	Any other symptoms?		

51. Do you wear contact lenses? Yes/No If yes, date of last exam by eye professional:_____

52. Are you on a waiver? Yes / No If yes, for what condition?_____

Date of Last Physical:_____ PATIENT'S SIGNATURE_____

PATIENT IDENTIFICATION

Last Name, First, MI:_____ **SSN:** _____- ____ -_____ **Rank or Rate:**_____

Designator/NEC/MOS:_____ **Service:**_____ **Patient's Command:**_____Phone:_____

UIC/ RUC:_____ **Aircraft:**_____ **Flight Hours: Total**_____ **Last 6 months**_____

AGE:_____ **Date of Birth:**_____ **Gender: M / F**

B. Physical Exam

53. Sitting Blood Pressure_____/_____ 54. Pulse_____ 55. Height_____ 56. Weight_____

57. %Body Fat (If exceeds Height vs. Weight)_____

58. DISTANT VISION AFVT/20 ft eye lane/Titmus II		59. REFRACTION				60. NEAR VISION		
RIGHT 20/	CORR TO 20/	BY	S	C X	OD	20/	CORR TO 20/	OD
LEFT 20/	CORR TO 20/	BY	S	C X	OS	20/	CORR TO 20/	OS
BOTH 20/	CORR TO 20/	NEAR ADD:			OU	20/	CORR TO 20/	OU

61. HETEROPHORIA *(Specify distance)* ES EX RH LH
or: **NOHOSH**

62. FIELD OF VISION (and Amsler Grid for USAF)

63. COLOR VISION (Test used and result)
FALANT/PIP/Ishihara

64. DEPTH PERCEPTION(Test used and score)
AFVT/ Verhoeff/TitmusII/Randot, UNCORRECTED/CORRECTED

65. INTRAOCULAR TENSION
OD OS

66. Audiogram	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz
Right Ear						
Left Ear						

67. Other Findings (address waivered condition, if any):_____

Breasts/Pelvic/PAP:_____Mammography (if req):_____

❑ Dental Exam Verified (Current within last 12 months) Date:_____ Qualified?_____

❑ Medical Readiness Items Verification (Immunizations, spectacles, etc)_____

❑ Annual HIV Verification: Date: _____

C. Flight Surgeon Comments

Item #	Comment	CD/ NCD	ICD code	Waiver Status

D. Impression & Disposition

❑ PQ/AA, Class I / II / III, SG 1 / 2 / 3: _____ (or Qualified USAF FLYING CLASS II / IIA / IIB / IIC)

❑ NPQ/AA (or Not Qualified)

❑ Waiver: Recommended / Pending / Granted (Date)_____ Rec. Continue?_____ CO Concurs? _____

❑ Special Duty Medical Abstract (NAVMED 6150/2) Entry Made by _____

❑ Clearance Notice Given (NAVMED 6410/2 or AF Form 1042)

❑ Special Submission requirements or waiver restrictions: _____

FLIGHT SURGEON'S SIGNATURE_____ Stamp:_____ Date:_____

PATIENT IDENTIFICATION (IF NOT SHOWN ON OTHER SIDE)

Last Name:_____First_____ M. I.:___ SSN:_____-____-_____