

Initial Pilot Questionnaire



Welcome to our Aviation Medical Office. We take pride in servicing the medical needs of some of the best pilots in the world! To expedite your medical, please answer the following questions.

Type of Permit/Licence Desired	Aviation Permit/Licence Held	Permit/Licence Number
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Personal Information

First Name	Middle Name	<input type="checkbox"/> I have no middle name	
Surname	Former Surname (if applicable)		
Mailing Address			
Phone - Business	Phone - Home	Phone - Cell	
Email	Date of Birth (Y/M/D)	Country of Birth	
Health Care Number & Province	Family Doctor (<i>Dr. Adams is not your family doctor</i>)	Next of Kin	
Highest Level of Education Completed	Citizenship		
Occupation	Employer		

Pilot Flight Time	Last 90 Days	Last 12 Months	Total
City, Province of Last Aviation Medical	Date of Last Aviation Medical (Y/M/D)	Date of Last Audiogram (Y/M/D) <input type="checkbox"/> unknown	Date of Last ECG (Y/M/D) <input type="checkbox"/> unknown
Primary type of flying intended <input type="checkbox"/> recreational <input type="checkbox"/> business <input type="checkbox"/> career			
Have you ever been denied an aviation license for medical reasons?			<input type="checkbox"/> yes <input type="checkbox"/> no
Have you had an aircraft accident since your last medical?			<input type="checkbox"/> yes <input type="checkbox"/> no
Are you receiving a pension or disability income?			<input type="checkbox"/> yes <input type="checkbox"/> no
Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no	Number of drinks per week	
Do you smoke?	<input type="checkbox"/> yes <input type="checkbox"/> no	Number of cigarettes per day	
Have you used other recreational drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no	Type & Date of last use	
Do you wear <input type="checkbox"/> glasses <input type="checkbox"/> reading glasses <input type="checkbox"/> contacts <input type="checkbox"/> had eye surgery			
Do you have color vision difficulties? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, have you passed the color lantern test? <input type="checkbox"/> yes <input type="checkbox"/> no			
Hair Color <input type="checkbox"/> bald <input type="checkbox"/> black <input type="checkbox"/> blonde <input type="checkbox"/> brown <input type="checkbox"/> grey <input type="checkbox"/> red <input type="checkbox"/> salt/pepper	Eye Color <input type="checkbox"/> black <input type="checkbox"/> blue <input type="checkbox"/> brown <input type="checkbox"/> green <input type="checkbox"/> grey <input type="checkbox"/> hazel		

Please Turn Over

Do you take, or have recently stopped taking, any medications? <input type="checkbox"/> yes <input type="checkbox"/> no	Details
Have you ever had surgery? <input type="checkbox"/> yes <input type="checkbox"/> no	Details
Have you ever been in the hospital for anything other than surgery? <input type="checkbox"/> yes <input type="checkbox"/> no	Details
Have you ever been treated for a medical reason? (<i>high blood pressure, depression, etc</i>) <input type="checkbox"/> yes <input type="checkbox"/> no	Details
Do you have any allergies? <input type="checkbox"/> yes <input type="checkbox"/> no	Details

Do you have any of the following conditions/concerns?

- | | | | | | |
|--|---|---------------------------------------|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> bladder | <input type="checkbox"/> color vision | <input type="checkbox"/> epilepsy | <input type="checkbox"/> kidney | <input type="checkbox"/> skin |
| <input type="checkbox"/> allergies | <input type="checkbox"/> bleeding | <input type="checkbox"/> constipation | <input type="checkbox"/> gallbladder | <input type="checkbox"/> liver | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> blood pressure | <input type="checkbox"/> cough | <input type="checkbox"/> headaches | <input type="checkbox"/> nerves | <input type="checkbox"/> stomach |
| <input type="checkbox"/> appetite | <input type="checkbox"/> bronchitis | <input type="checkbox"/> depression | <input type="checkbox"/> hearing | <input type="checkbox"/> pneumonia | <input type="checkbox"/> swelling |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> bruising | <input type="checkbox"/> diabetes | <input type="checkbox"/> heart | <input type="checkbox"/> seizures | <input type="checkbox"/> thyroid |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer | <input type="checkbox"/> digestion | <input type="checkbox"/> jaundice | <input type="checkbox"/> sexual concerns | <input type="checkbox"/> vision |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> chest pain | <input type="checkbox"/> drug abuse | | | |

Is there anything else concerning you not mentioned above?

Relative	Age (If Alive)	Current Health Details *	Age at Death	Cause of Death	How Long Ill?
Father		<input type="checkbox"/> healthy			
Mother		<input type="checkbox"/> healthy			
Siblings <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
Spouse		<input type="checkbox"/> healthy			
Children <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			
<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> healthy			

* In particular, we are interested in diabetes, heart disease, stroke, high blood pressure and mental illness. Are there any of these conditions that seem to run in your family?

**Thank you for your kind cooperation in answering all the questions.
It will make your medical go more smoothly – honest!**