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

Personal Information

First Name	Middle Name ☐ 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 *(Dr. Adams is not your family doctor)*

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) ☐ unknown	Date of Last ECG (Y/M/D) ☐ unknown

Primary type of flying intended ☐ recreational ☐ business ☐ career			
Have you **ever** been denied an aviation license for medical reasons?			☐ yes ☐ no
Have you had an aircraft accident since your last medical?			☐ yes ☐ no
Are you receiving a pension or disability income?			☐ yes ☐ no
Do you drink alcohol?	☐ yes ☐ no		Number of drinks per week
Do you smoke?	☐ yes ☐ no		Number of cigarettes per day
Have you used marijuana?	☐ yes ☐ no		Date of last use
Have you used other recreational drugs?	☐ yes ☐ no		Type & date of last use
Do you wear ☐ glasses ☐ reading glasses ☐ contacts ☐ had eye surgery			
Do you have color vision difficulties? ☐ yes ☐ no If yes, have you passed the color lantern test? ☐ yes ☐ no			
Hair Color ☐ bald ☐ black ☐ blonde ☐ brown ☐ grey ☐ red ☐ salt/pepper		Eye Color ☐ black ☐ blue ☐ brown ☐ green ☐ grey ☐ hazel	

Please Turn Over

Do you take, or have recently stopped taking, any medications? ☐ yes ☐ no	Details
Have you ever had surgery? ☐ yes ☐ no	Details
Have you ever been in the hospital for anything other than surgery? ☐ yes ☐ no	Details
Have you ever been treated for a medical reason? *(high blood pressure, depression, etc)* ☐ yes ☐ no	Details
Do you have any allergies? ☐ yes ☐ no	Details

Do you have any of the following conditions/concerns?

☐ alcohol abuse	☐ bladder	☐ color vision	☐ epilepsy	☐ kidney	☐ skin
☐ allergies	☐ bleeding	☐ constipation	☐ gallbladder	☐ liver	☐ sleeping
☐ anxiety	☐ blood pressure	☐ cough	☐ headaches	☐ nerves	☐ stomach
☐ appetite	☐ bronchitis	☐ depression	☐ hearing	☐ pneumonia	☐ swelling
☐ arthritis	☐ bruising	☐ diabetes	☐ heart	☐ seizures	☐ thyroid
☐ asthma	☐ cancer	☐ digestion	☐ jaundice	☐ sexual concerns	☐ vision
☐ blackouts	☐ chest pain	☐ 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		☐ healthy			
Mother		☐ healthy			
Siblings ☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ healthy			
Spouse		☐ healthy			
Children ☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ healthy			
☐ M ☐ F		☐ 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!