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Aeromedical Solutions

Full name:			
Do you have or have you ever had or been told you have:	***No***	***Yes***	***Details if answered 'yes'***
Incapacitating travel sickness			
Any allergies requiring hospitalisations or on-going carriage of Epipens			
Fear of flying			
Frequent or severe headaches/migraines			
Head injury or concussion			
Dizziness, faints or blackouts			
Fits, convulsions or epilepsy			
Anxiety state, Panic disorder			
Mood disorder e.g. Depression			
Suicide attempt			
Bipolar disorder			
Phobias			
Eating disorders e.g. anorexia or bulimia			
Any tropical diseases e.g. Malaria or Dengue Fever, Tuberculosis (TB)			
Problems with your immune system			
Anaemia, sickle cell disease or any other blood disorders			
A positive HIV test			
Positive Hepatitis B surface antigen test			
Positive Hepatitis C Antibody (Anti HCV) test			
Hay fever, asthma, or respiratory problems			

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Full name:			
Do you have or have you ever had or been told you have:	***No***	***Yes***	***Details if answered 'yes'***
Any allergies to vaccinations?			
Any allergies to medications?			
Heart complaints of any kind, e.g. heart surgery, irregular heart beats, heart disease, stroke			
High blood pressure-If you have had a recent blood pressure reading please provide result:			
Stomach pain or bowel problems other than occasional indigestion e.g. ulcers, colitis, irritable bowel etc.			
Spleen removal			
Kidney or bladder diseases e.g. stones			
Sleep problems lasting for more than a few days or snoring problems			
Diabetes, impaired glucose regulation or endocrine disorders			
Have you had a vision check in the last year?			
Do you wear glasses?			
Do you wear contact lens?			
Corrective eye surgery or eye problems, other than wearing glasses or contact lenses			
Colour deficiency/ blindness			
Nose, Throat, Speech disorders or Sinus problems			
Ear or hearing problems/ Hearing aids			
Significant pain in the ears when flying			
Skin diseases e.g. Psoriasis			
Do you have identifying marks e.g. birth marks or tattoos?			
Back trouble e.g. lumbago, sciatica, slipped disc or significant scoliosis			
Rheumatism, Arthritis, joint or limb problems			

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Full name:			
Do you have or have you ever had or been told you have:	**No**	**Yes**	**Details if answered 'yes'**
Any surgical operations including cosmetic procedures			
Growths, tumours or malignancies			
If female, any gynaecological problems			
Any illness that caused you to take time off work for a period longer than 20 days in a single year			
Sustained any serious injury, e.g. fracture or dislocation, resulting in on going problems?			
Do you have any learning disabilities e.g. dyslexia?			
Drug and or Alcohol addiction or being diagnosed with Substance Use disorder ever.			
Have you ever been charged with an offence relating to drugs or alcohol?			
Any illness / condition not mentioned above			
Any admissions to the hospital			
Please list any medications/ food supplements/ diet pills/herbal treatments or other substances that you are currently taking: If not applicable please tick "NO"			
NB: if you answer YES to any of these questions please bring a report or letter from your treating doctor detailing the condition and or any treatment. Failure to provide the information MAY result in a delay to your application and license issuance.			

I hereby declare that I have carefully considered my statements made above and that to the best of my belief they are complete and correct and that I have not withheld ANY relevant information or made any misleading statements. I am aware that failure to make a full and honest declaration may result in my application and certification being invalidated or withdrawn or in disciplinary action by my employers.

Signature: Date: