



AVIATION MEDICAL REPORT

PERSONAL INFORMATION

1. Name:	Surname	First name(s)	
2. Postal address			Postal code
3. Telephone numbers	During office hours	After hours	Cellular
4. Date of birth (dd/mm/yyyy)		5. Eye colour	
6. Hair colour		7. Gender	
8. Nationality		9. Occupation	

FLIGHT MEDICAL INFORMATION

1. Identity/ passport number		2. Licence number					
3. Medical class applied for		4. Licence type					
5. Flight time			6. Type of flying intended			7. Previous medical examination	
Last 6 months	Last 12 months	Total	Recreation	Business	Career	Doctor	Date
Previous restrictions/ protocols				Medication used previous 3 months: (name and dosage)			
SANDF	1. Number	2. Rank	3. Previous medical classification		4. Arm of service, unit, station		

MEDICAL HISTORY

Kindly mark the applicable block. If yes please provide complete details below. If the space is insufficient, add supplementary notes on separate sheet.

Family history	Y	N	Y	N	Y	N
1. Heart disease or high blood pressure			13. Dizziness or unsteadiness		28. Heart murmur / valve problem	
2. Epilepsy or convulsions			14. Unconsciousness (for any reason)		29. Any blood or thyroid disorder	
3. Glaucoma or blindness			15. Head injury or concussion		30. Heartburn/ frequent indigestion	
4. Diabetes/sugar sickness			16. Epilepsy or fits of any kind		31. Stomach, liver / intestine problem	
5. Mental illness			17. Any other neurological disorder		32. Bleeding from the rectum	
Have you ever been			18. Any mental/psychological disorder		33. Kidney stone/ blood in urine	
6. Refused insurance on medical grounds			19. Suicide attempt		34. Sugar or protein in the urine	
7. Refused a flying licence, or grounded			20. Eye or vision trouble other than specs		35. Diabetes (sugar sickness)	
8. Convicted of a civil / criminal offence			21. Motion sickness requiring treatment		36. Muscle, bone or joint problems	
9. Medically rejected for military service			22. Hearing or speech disorders		37. Prostate/ Gynaecological problems	
Since your last medical, have you been			23. Hay fever or allergy		38. STD, excluding HIV	
10. Admitted to hospital			24. Asthma or lung disease		39. Malignant tumour or cancer	
11. Involved in a vehicle/aircraft accident			25. Tuberculosis or pneumonia		40. Weight loss (without dieting)	
Have you ever had / do you now have			26. Heart disease or high blood pressure		41. Malaria/ other tropical disease	
12. Frequent or severe headaches			27. Chest discomfort, pain / palpitations		42. Any other illness or injury	

Mark appropriate column	N	ABN	Mark appropriate column	N	ABN	Mark appropriate column	N	ABN		
7. Head, face, scalp and neck			13. Heart			19. Lower limbs				
8. Nose and sinuses			14. Vascular & lymphatics			20. Spine & musculo-skeletal				
9. Ears and eardrums			15. Abdomen			21. Skin				
10. Valsalva (patent bilaterally)			16. Genito-urinary system			22. Identifying body marks				
11. Romberg			17. Neurological system			23. Psychological evaluation				
12. Lungs, chest and breast			18. Upper limbs			24. Any other problems				
DESCRIPTION OF FINDINGS (<i>Describe every abnormality in detail. Attach additional pages, if necessary.</i>)										
VISUAL EXAMINATION										
History	Y	N	10. Distance vision			11. Intermediate vision		12. Near vision		
1. Exam performed by AME			Uncorrected	Corrected	Uncorrected	Corrected	Uncorrected	Corrected		
2. Spectacles used regularly			Both							
3. Contact lenses used regularly			Right							
Examination			Left							
4. Orbit and adnexae			13. Phorias			14. Colour vision				
5. Eye movements			Distance vertical		Test used	Number of plates	Number correct			
6. Visual fields			Distance horizontal							
7. Near point of convergence			Near vertical		Lantern test previously performed? State date and result					
8. Pupils			Near horizontal							
9. Fundoscopy			15. Previous eye surgery performed – state date and procedure							
AUDIOGRAM (dB hearing loss)					SPECIAL INVESTIGATIONS					
	250	500	1000	2000	3000	4000	6000	Date performed	Result	Next due
Right								1. Resting ECG		
Left								2. Stress-ECG		
ANY OTHER TESTS PERFORMED Type and result					3. Lung function test					
					4. Lipogram					
					5. Chest X-ray					
CVD RISK FACTOR ASSESSMENT					SUMMARY OF FINDINGS					
Item	Y	N	Item	Y	N	Significant history:				
(+) Family history			Obesity							
Age and gender			Hypertension							
Smoking			High cholesterol			Abnormal findings:				
Exercise			Diabetes							
Comments										
								Additional reports required:		

AVIATION MEDICAL EXAMINER ASSESSMENT AND DECLARATION

I hereby certify that I have personally reviewed the medical history and personally examined the applicant named in this report. This report and attachments embody my findings completely and correctly.

Recommendation	Dates	Restrictions/comments
Fit	From	
Temporary unfit		
Class	To	
Licence type		

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SIGNATURE OF EXAMINER	NAME IN BLOCK LETTERS	DATE
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EXAMINER'S CODE	
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EXAMINER'S TELEPHONE NUMBER	
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EXAMINER'S ADDRESS	
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FOR OFFICE USE ONLY

This certifies that the applicant is	
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