

|  |  |   |   |              |
|--|--|---|---|--------------|
| Initial <input type="checkbox"/>   | Medical Examination                          | Place   | Date  |              |
| Renewal <input type="checkbox"/>   |  |   |   |              |
| 1 FULL NAME (Mr/Mrs/Miss/Ms)<br>(Block Letters, Surname first)   |  |   |   |              |
| 2 PERMANENT ADDRESS  |  |   | Telephone No.                                 |              |
| 3 POSTAL ADDRESS (if different from above)   |  |   | Telephone No.                                 |              |
| 4 PLACE AND DATE OF BIRTH  | 5 AGE  | 6 OCCUPATION  | 7 EMPLOYER (if applicable)                    |              |
| 8 TYPE OF HK LICENCE(S) HELD OR APPLIED FOR  |  |   |   |              |
| Airline Transport Pilot  | Student Pilot                                | Licence Number(s)   | Expiry Date(s) of last Medical Certificate(s) |              |
| Commercial Pilot   | ATCO   |   |   |              |
| Flight Engineer  | Others (please specify)                      | Expiry Date(s) of 10 Year Licence(s)  | Hours flown since last Medical                |              |
| Private Pilot  |  |   | Total hours flown                             |              |
| PPL Inst Rating  |  |   |   |              |
| 9 Give details of involvement in any aircraft accident since last Medical  |  |   | 10 Do you smoke?<br>YES/NO                    |              |
|  |  |   | If 'YES' give details                         |              |
| 11 Name and Address of own Medical Practitioner  |  |   | Telephone No.                                 |              |
| 12 Any medication presently being prescribed?<br>YES/NO  |  | If 'YES' give description, purpose and by whom prescribed   |   |              |
| 13 MEDICAL HISTORY — if 'YES' please tick and describe in 'REMARKS'  |  |   |   |              |
| <b>Family History of</b>   |  | <b>Review of Systems — Have you a history of</b>  |   |              |
| (a) Heart disease  | (i) Eye trouble, refractive surgery          | (s) Frequent or severe headaches  |   |              |
| (b) High/Low blood pressure  | (j) Hay fever or asthma                      | (t) Dizziness, fainting or unconsciousness  |   |              |
| (c) Epilepsy   | (k) Heart trouble or high/low blood pressure | (u) Malaria or tropical disease   |   |              |
| (d) Mental illness   | (l) Kidney stone or blood in urine           | (v) A positive HIV test   |   |              |
| (e) Diabetes   | (m) Sugar or albumin in urine                | (w) Alcohol or related problem  |   |              |
| <b>Have you ever been</b>  | (n) Stomach trouble                          | (x) Use of opioids, cannabinoids, sedatives, hypnotics, cocaine, hallucinogens, solvents or other psychoactive substances |   |              |
| (f) Refused life insurance   | (o) Head injury/concussion                   |   |   |              |
| (g) Refused an aviation licence or medical certificate   | (p) Epilepsy or fits                         |   |   |              |
| (h) Convicted of a civil or criminal offence   | (q) Motion sickness requiring Drugs          | (y) Admission to hospital   |   |              |
|  | (r) Nervous trouble of any sort              | (z) Any other illness or injury   |   |              |
| <b>REMARKS</b> —if no change since last report, so state   |  |   |   |              |
| 14 Details of any illness, accident, disability or admission to hospital since last Medical Examination (or in the six months preceding initial examination)   |  |   |   |              |
| Date(s)  | Details                                      | Doctor's Name and Address   |   |              |
|  |  |   |   |              |
| 15 Declaration   |  |   |   |              |
| I hereby declare that I have carefully considered the 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 statement. I understand that if I have, with intent to deceive, made any false representation for the purpose of procuring for myself a medical certificate, I may be guilty of a criminal offence.                 |  |   |   |              |
| <b>Consent to obtaining of medical information</b>   |  |   |   |              |
| I hereby consent to the Civil Aviation Department (so long as I hold or am an applicant for a medical certificate) obtaining information about my health from any medical adviser or hospital consulted by me.   |  |   |   |              |
| Signed .....   |  | Witness' Signature .....  |   |              |
| Date .....   |  | Witness' Name in BLOCK LETTERS .....  |   |              |
| Witness' Address .....   |  |   |   |              |
| 16 See AME Manual for periodicity or routine ECG, CXR and Audiogram. All tests, reports and tracings should be securely attached to the WHITE examination report. AMEs are advised to retain the YELLOW copy of the examination report and copies of other reports for future reference. AMEs comments including recommendations for further progress reports and specialist consultations should be submitted on a separate sheet of paper. |  |   |   |              |
| Signature of AME<br>NAME IN BLOCK CAPITALS   | <b>17 OFFICIAL USE ONLY</b>                  |   | Annex 1 requirements                          |              |
|  | Date of next ECG<br>AUDIO                    | Medical Certificate issued: YES/NO  | Class .....                                   | Attained     |
|  | Signature of ASSESSOR                        |   |   | Not Attained |
|  | Date   |   |   | Class One    |
|  |  |   |   | Class Two    |
|  |  |   | Class Three                                   |              |
|  |  |   | Restrictions:                                 |              |

## REPORT OF MEDICAL EXAMINATION

|  |   |  |   |  |
|--|---|--|---|--|
| 18 Height <span style="float: right;">cm</span>  | 19 Weight <span style="float: right;">kg</span> | 20 Chest Insp <span style="float: right;">cm</span><br>Exp <span style="float: right;">cm</span> | 21 Waist <span style="float: right;">cm</span>  |  |
| 22 Identifying Marks, Scars, Tattoos, Deformities:<br>(i) Colour of hair:<br>(ii) Colour of eyes: <span style="float: right;">(iii) Physical Impression:</span>  |   |  | 23 Date of last ECG<br>Audio  |  |
| Please complete each item and place a tick in the appropriate column   |   | Normal   | Abnormal  |  |
| NOTES: Enter item number before each comment<br>Any abnormal finding should be given in detail<br>Attach additional sheet(s) if necessary  |   |  |   |  |
| 24 Head Neck   |   |  |   |  |
| 25 Mouth Throat Teeth  |   |  |   |  |
| 26 Sinuses Nose  |   |  |   |  |
| 27 Ears Drums Valsalva   |   |  |   |  |
| 28 Lungs Chest incl Breast   |   |  |   |  |
| 29 Heart Size, Auscultation  |   |  |   |  |
| 30 Vascular System Varicose Veins  |   |  |   |  |
| 31 Blood Pressure-Systolic/Diastolic (Recumbent) Pulse Rate  |   |  |   |  |
| 32 Abdomen, Hernia   |   |  |   |  |
| 33 Liver Spleen  |   |  |   |  |
| 34 Anus Rectum (Haemorrhoids, Fistula, Prostate)   |   |  |   |  |
| 35 Genito-urinary System   |   |  |   |  |
| 36 Endocrine System  |   |  |   |  |
| 37 Upper, Lower Limbs Joints   |   |  |   |  |
| 38 Spine, Spinal Movement  |   |  |   |  |
| 39 Neurological (Reflexes, equilibrium, etc.)  |   |  |   |  |
| 40 Skin  |   |  |   |  |
| 41 Psychiatric   |   |  |   |  |
| 42 Last Menstruation Date  | Pelvic Examination (if applicable)              |  |   |  |
| <b>43 EYES VISUAL ACUITY</b>   |   |  |   |  |
| Lids, Pupils, Lens, Media, Fundi   | Normal  | Abnormal   | Does the candidate wear glasses or contact lenses <span style="float: right;">YES/NO</span>   |  |
| Distant Vision (Standard Test Types)   | Without Glasses                                 | Right  | Left  |  |
|  | With Glasses                                    | Binocular  | Prescription of glasses or contact lenses if applicable   |  |
| Intermediate Vision (N type at 100 cm)<br><i>[Able to read N14 at 100cm]</i>   | Without Glasses                                 |  |   |  |
|  | With Glasses                                    |  |   |  |
| Near Vision (N type at 30 to 50 cm)<br><i>[Able to read N5 in the range 30 to 50 cm]</i>   | Without Glasses                                 |  |   |  |
|  | With Glasses                                    |  |   |  |
| Accommodation in cm<br>(Near point 30 cm with or without lenses)   | Without Glasses                                 |  |   |  |
|  | With Glasses                                    |  |   |  |
| Field of vision by confrontation test  | Normal  | Abnormal   | Power of convergence in cm<br>Result of cover test  |  |
| 44 COLOUR PERCEPTION <i>(Initial medical exam only—All licences)</i><br>Tested by pseudoisochromatic (Ishihara) plates<br>(if abnormal a Lantern test MUST be performed for ALL licences)<br>Tested by an approved Colour Perception Lantern | Normal  | Abnormal   | Remarks:  |  |
|  |   |  |   |  |
|  |   |  |   |  |
| 45 MEASURE OF HETEROPHORIA<br>Maddox Rod<br>or<br>Maddox Wing  | Exophoria                                       | Esophoria  | Hyperphoria   |  |
|  |   |  |   |  |
| NOTES: Form DCA 153(Oph) shall be attached in accordance with para. 3.2.9.11(b) of the Guidance Notes for AME  |   |  |   |  |
| <b>46 AUDITORY ACUITY</b>  |   |  |   |  |
| Any hearing difficulty with <i>Conversational</i> voice at 2 metres with back to examiner? <span style="float: right;">YES/NO</span>   |   |  |   |  |
| At what distance from examiner can <i>Forced Whisper</i> be heard in each ear separately? Right: Left:<br>(when appropriate) Rinne : Weber :   |   |  |   |  |
| AUDIOMETRY<br>(for periodicity see AME Manual)   | Frequency                                       | Right  | Left  |  |
|  | 3000  |  | Max Permitted Loss  |  |
|  | 2000  |  | 50  |  |
|  | 1000  |  | 35  |  |
|  | 500   |  | 35  |  |
| 47 URINALYSIS Albumin ..... Sugar ..... Blood ..... Other .....  |   |  | 49 DRUG SCREEN (Initial medical and when clinically indicated)<br>Alcohol ..... Cocaine .....<br>Amphetamines ..... Opiates .....<br>Cannabinoids ..... Other .....<br>Comments:— |  |
| 48 HIV TEST RESULTS (Initial medical and when clinically indicated)<br>Test used: Result:  |   |  |   |  |