

Initial <input type="checkbox"/>		Medical Examination		Place		Date (dd/mmm/yy):	
Renewal <input type="checkbox"/>							
1 SURNAME				Title		Telephone No	
OTHER NAMES							
2 ADDRESS						Email	
3 PLACE OF BIRTH		4 DATE OF BIRTH (dd/mmm/yy)		5 AGE	6 EMPLOYER (if applicable)		7 OCCUPATION
8 DETAILS OF HK LICENCE AND MEDICAL CERTIFICATE HELD OR APPLIED FOR						Licence Number(s)	
ATPL <input type="checkbox"/> Single Crew <input type="checkbox"/> Multi Crew <input type="checkbox"/>		Expiry Date(s) of last Medical Certificate(s) (dd/mmm/yy)		Hours flown since last medical		Total hours flown	
CPL <input type="checkbox"/> Single Crew <input type="checkbox"/> Multi Crew <input type="checkbox"/>							
PPL <input type="checkbox"/> PPL Inst Rating <input type="checkbox"/> Student Pilot <input type="checkbox"/>							
FE <input type="checkbox"/> ATCO <input type="checkbox"/> Others <input type="checkbox"/>		Please specify:					
9 Any aircraft/incident since last medical? YES/NO (if yes, please give details)							
Date (dd/mmm/yy):				Place:			
Details:							
10 LAST MEDICAL EXAMINATION				Date (dd/mmm/yy)		Place	
AMEs Name				Result			
11 Name and Address of own Medical Practitioner						Telephone No	
						Email	
12 List ALL MEDICATIONS CURRENTLY TAKEN whether prescribed by a doctor or over-the-counter. (Please include vitamins, supplements and herbal medicines)							
Name (Generic)		Dose	Date started	Purpose		By Whom Prescribed	
(a)							
(b)							
(c)							
(d)							
(e)							
13 Do you smoke? YES/NO/NEVER. If yes or no, give details						14 State weekly alcohol intake in units:	
15 MEDICAL HISTORY -- Have you EVER had any of the following? Please tick YES or NO. If 'YES' describe in the 'Remarks' column or in Para 20							
				Yes		No	
				Remarks			
(a) Eye trouble, refractive surgery							
(b) Ear disease or deafness							
(c) Motion sickness requiring medication							
(d) Hayfever or allergy							
(e) Frequent or severe headaches							
(f) Dizziness, fainting or unconsciousness							
(g) Epilepsy or fits							
(h) Head injury or concussion							
(i) Psychiatric or nervous trouble of any sort							
(j) Asthma or other lung disorder							
(k) Heart trouble or high/low blood pressure							
(l) Anaemia or other blood disorder							
(m) Stomach, liver or intestinal disorder							
(n) Diabetes, thyroid or other hormone disease							
(o) Sugar or protein in the urine							
(p) Kidney stone or blood in the urine							
(q) Musculo-skeletal disorder							
(r) Malaria or other tropical disease							
(s) A positive HIV test							
(t) Alcohol/substance abuse or related problem							
(u) Use of opioids, cannabinoids, sedatives, hypnotics, cocaine, hallucinogens, solvents, recreational drugs or other psychoactive substances							
(v) Admission to hospital overnight							
(w) Any other illness or injury							

Applicant's Name :

16 Have you ever been: Please tick YES or NO. If 'YES' describe in the 'Remarks' column or in Para 20  
YES NO Remarks

(a) Refused life insurance

(b) Denied an aviation medical certificate

(c) Convicted of a civil or criminal offence

17 Have you a family history of: Please tick YES or NO. If 'YES' describe in the 'Remarks' column or in Para 20  
YES NO Remarks

(a) Heart disease

(b) High/Low blood pressure

(c) Epilepsy

(d) Mental illness

(e) Diabetes

18 Females only: Please tick YES or NO. If 'YES' describe in the 'Remarks' column or in Para 20  
YES NO Remarks

(a) Are you pregnant?

(b) Have you a history of gynae problems?

19 Since last medical, have you had any illness, accident, admission to hospital or started long term medication? YES/NO If 'YES' describe in Para 20

20 REMARKS - if no change since last report, so state. If insufficient room, use separate sheet of paper.

21 **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.

**Consent to obtaining of medical information.** 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 ..... Date (dd/mmm/yy)..... AME's (Witness) Signature .....

AME's Name..... Telephone no.(s)..... email address.....

AME's Address .....

22 AME please comment on Page 4 on all items answered YES above and detail your recommendations for further progress reports and specialist consultations. All tests, reports and tracings should be securely attached to the examination report. You are advised to make photocopies of the examination report and copies of other reports for future reference.

**REPORT OF MEDICAL EXAMINATION**

Applicant's Name :

<b>23</b> Height (cm)	<b>24</b> Weight (kg)	<b>25</b> BMI	<b>26</b> Physical Impression	<b>27</b> Identifying marks, Scars, Tattoos, Deformities						
<b>28</b> Hair colour	<b>29</b> Eye colour	<b>30</b> Pulse	<b>31</b> Blood pressure (recumbent)	1 <sup>st</sup>	2 <sup>nd</sup> (if indicated)	3 <sup>rd</sup> (if indicated)				
Please tick for each item.		Normal	Abnormal	NOTES: Enter item number before each comment. Any abnormal finding should be given in detail. Attach additional sheet(s) if necessary						
<b>32</b> Head	Neck									
<b>33</b> Eyes - Lids and orbits										
<b>34</b> Eyes - Pupils, Lens, Media, Fundi										
<b>35</b> Eyes - Visual fields by confrontation										
<b>36</b> Eyes - Ocular movements, nystagmus										
<b>37</b> Mouth	Throat	Teeth								
<b>38</b> Sinuses	Nose									
<b>39</b> Ears	Drums	Valsalva								
<b>40</b> Lungs	Chest incl Breast									
<b>41</b> Heart	Size, Auscultation									
<b>42</b> Vascular System	Varicose Veins									
<b>43</b> Abdomen, Hernia										
<b>44</b> Liver	Spleen									
<b>45</b> Anus	Rectum	Only if indicated								
<b>46</b> Genito-urinary System										
<b>47</b> Endocrine System										
<b>48</b> Upper, Lower Limbs	Joints									
<b>49</b> Spine,	Spinal Movement									
<b>50</b> Neurological (Reflexes, equilibrium, etc.)										
<b>51</b> Skin										
<b>52</b> Psychiatric & mental status										
<b>53</b> Pelvic Examination (if applicable)				<b>54</b> Last Menstruation Date (Female only) (dd/mm/yy):						
<b>55 VISUAL ACUITY</b>			Right	Left	Binocular	Does the candidate wear glasses or contact lenses: YES/NO Prescription of glasses or contact lenses if applicable				
Distant Vision (Standard Test Types)			Without Glasses							
			With Glasses							
Intermediate Vision (N type at 100 cm) <i>[Able to read N14 at 100 cm]</i>			Without Glasses			RIGHT	Distant	S	C	A
			With Glasses				Near			
Near Vision (N type at 30 to 50 cm) <i>[Able to read N5 in the range 30 to 50 cm]</i>			Without Glasses			LEFT	Distant	S	C	A
			With Glasses				Near			
Accommodation in cm (Near point 30 cm with or without lenses)			Without Glasses							
			With Glasses							
<b>56 MEASURE OF HETEROPHORIA</b> (by Maddox Rod at 6 M)			Exophoria	Esophoria	Hyperphoria	<b>57</b> Power of convergence in cm Result of cover test				
<b>58 COLOUR PERCEPTION</b> (Initial medical examination only - ALL Licences).						Number correct	Number incorrect			
Tested by pseudoisochromatic (Ishihara) plates. State number of correct and incorrect plates										
Tested by an approved Colour Perception Lantern. (must be tested if plates test is abnormal) State name of lantern. State number of correct and incorrect plates										
<b>59 AUDITORY ACUITY</b>										
Any hearing difficulty with <i>Conversational</i> voice at 2 metres with back to examiner? YES/NO										
At what distance from examiner can <i>Forced Whisper</i> be heard in each ear separately? Right: Left: (when appropriate) Rinne : Weber :										
<b>60 AUDIOMETRY</b>				<b>61 ECG Report (Summary)</b>						
Frequency	Right	Left	Max Permitted Loss							
3000			50							
2000			35							
1000			35							
500			35							
Remarks				<b>62 CXR Report (Summary) Initial exam only</b>						
<b>63</b> Date of last Special examinations (dd/mm/yy): ECG Audio OPH				NOTES: ECG tracing and report, CXR report and ophthalmological report (DCA 153 (Oph) should be attached to this report. For frequency of ECG, audiogram and ophthalmic examination, see the Guidance Notes for AME.						
<b>64 URINALYSIS</b> Albumin ..... Sugar ..... Blood ..... Other .....					<b>66 DRUG SCREEN</b> (when clinically indicated) Alcohol..... Cocaine..... Amphetamines..... Opiates..... Cannabinoids..... Other..... Comments: -					
<b>65 HIV TEST RESULTS</b> (initial medical and when clinically indicated) Test used: Result:										

Applicant's Name :

67 Comments - Additional comments from AME on Items 12-20 and 23-66, including any items answered YES in Items 15-19 and your recommendations for further progress reports and specialist consultations.

68 Medical Examiners declaration:

I hereby certify that I have personally examined the applicant named on this medical examination report and that this report with any attachments embodies my findings completely and correctly.

Signature of AME

NAME IN BLOCK CAPITALS

DATE COMPLETED (dd/mmm/yy)

69 For use by AMA and CAD ONLY Annex 1 requirements

	Attained	Not Attained	Medical Certificate issued : YES / NO Class .....
Class One			Date of next (dd/mm/yy): ECG AUDIO OPH
Class Two			Expiry Date of Medical Certificate (dd/mmm/yy):
Class Three			<input type="checkbox"/> Class 1 for single-crew commercial air transport operations carrying passengers .....
Limitations:			<input type="checkbox"/> Class 1 for commercial air transport operations other than (i) above .....
			<input type="checkbox"/> Class 2 .....
			<input type="checkbox"/> Class 3 .....
			Comments:
			Signature of ASSESSOR..... Date.....