**APPENDIX A: CABIN CREW INITIAL MEDICAL ASSESSMENT IN ACCORDANCE WITH PART-MED MED.C.005**

Complete this page fully using a black ball point pen and in block capitals **MEDICAL IN CONFIDENCE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname:** | **Previous surname(s):** | | **Title:** | | | | | | |
| **Forenames:** | **Date of birth:** | | **Sex:**  **Male**   **Female**  | | | | | | |
| **Place and country of birth:** | **Nationality:** | |  | | | | | | |
| **Address:**  **Postcode: Country:**  **Telephone No: Mobile No:** | | **GP Name: Address:**  **Telephone No:** | | | | | | | |
| Alcohol – state average weekly intake in units: | | Do you currently use any medication? Yes  No   If YES, state name of medication, dose, date started and why | | M | M | Y | Y | Y | Y |
| Do you smoke tobacco? Never  No Yes   If no, date stopped: | |

**General and medical history:** Do you have, or have you ever had, any of the following? YES (Y) or NO (N) must be ticked after each question. If you have ticked YES give details below.

Y N Y N Y N Y N

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Problem with distant or close vision |  |  | Stomach, liver or intestinal trouble |  |  | Alcohol, drug or substance abuse |  |  | **Females Only** |  |  |
| Glasses or contact lenses worn |  |  | Ear disorder |  |  | Attempted suicide |  |  | Gynaecological or menstrual problems |  |  |
| Eye disease or surgery |  |  | Hearing problem |  |  | Anaemia, sickle cell disease or other blood disorder |  |  | Are you pregnant? |  |  |
| Hay fever |  |  | Nose, throat or sinus disorder |  |  | Malaria or other tropical disease |  |  |  | | |
| Allergy |  |  | Speech difficulties |  |  | A positive HIV test |  |  | **Family history of:** |  |  |
| Asthma or lung problem |  |  | Headaches or migraine |  |  | Infectious disease |  |  | Heart disease |  |  |
| High blood pressure |  |  |
| Any form of heart or vascular disease or stroke |  |  | Epilepsy or seizure |  |  | Admission to hospital |  |  | High cholesterol level |  |  |
| Epilepsy |  |  |
| High blood pressure |  |  | Dizziness, episode of fainting or unconsciousness for any reason |  |  | Illness or injury not otherwise specified |  |  | Mental illness |  |  |
| Diabetes |  |  |
| Kidney stone or blood in urine |  |  | Neurological disorders |  |  | Skin disorder |  |  | Tuberculosis |  |  |
| Allergy, asthma or eczema |  |  |
| Diabetes or hormone disorder |  |  | Psychiatric or psychological trouble of any sort |  |  | Disorder affecting strength or movement or arthritis |  |  | Inherited disorder |  |  |
| Glaucoma |  |  |
| **Details:** | | | | | | | | | | | |
| **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.  **Signature:** ……………………………………………………………………………………………………. **Date:** …………………………………. | | | | | | | | | | | |