

# Flight Medical Clearance

APPLICANT MUST COMPLETE THIS MEDICAL HISTORY  
PLEASE TYPE OR PRINT CLEARLY IN DARK INK

LAST NAME:		FIRST NAME:		MIDDLE NAME:	
STREET ADDRESS:		CITY:		STATE:	ZIP:
DAY PHONE NUMBER:		CELL PHONE NUMBER:		E-MAIL ADDRESS:	
DOB (MM/DD/YYYY):	GENDER:	WEIGHT (Lbs):		HEIGHT (Inches):	
MISSION YOU ARE FLYING:				DATES (Approximate):	

DO YOU CURRENTLY USE ANY MEDICATION (Prescription or non-prescription)?  YES  NO

YES	NO	CONDITION	YES	NO	CONDITION
<input type="radio"/>	<input type="radio"/>	Do you use a cane or walker?	<input type="radio"/>	<input type="radio"/>	Are you intolerant to heat?
<input type="radio"/>	<input type="radio"/>	Do you require any splints, braces, or prosthetics?	<input type="radio"/>	<input type="radio"/>	Are you intolerant to cold?
<input type="radio"/>	<input type="radio"/>	Are you unable to climb a ladder without assistance?	<input type="radio"/>	<input type="radio"/>	Are you afraid of heights?
<input type="radio"/>	<input type="radio"/>	Are you unable to climb 2 flights of stairs without difficulty?	<input type="radio"/>	<input type="radio"/>	Is your vision uncorrectable to at least 20/40 (i.e., DMV standards)?
<input type="radio"/>	<input type="radio"/>	Are you unable to walk for 30 minutes without resting?	<input type="radio"/>	<input type="radio"/>	Are you incapable of wearing a tightly fitting respirator mask?
<input type="radio"/>	<input type="radio"/>	Are you unable to lift and control a weight of 45 pounds?	<input type="radio"/>	<input type="radio"/>	Do you require hearing aids?
<input type="radio"/>	<input type="radio"/>	Are you unable to jump safely from a 5-foot height?	<input type="radio"/>	<input type="radio"/>	Are you afraid of confined or small spaces?
<input type="radio"/>	<input type="radio"/>	Do you need to go to the bathroom more than every 2 hours?	<input type="radio"/>	<input type="radio"/>	Do you have problems at high altitude (i.e., above 4000 feet)?
<input type="radio"/>	<input type="radio"/>	Do you have urinary or fecal incontinence?	<input type="radio"/>	<input type="radio"/>	Any recent hospitalizations (last 3 months)?
<input type="radio"/>	<input type="radio"/>	Any heart or lung problems?	<input type="radio"/>	<input type="radio"/>	Any open wounds/sores requiring a dressing?
<input type="radio"/>	<input type="radio"/>	A stroke (CVA) or TIA?	<input type="radio"/>	<input type="radio"/>	A colostomy or indwelling catheter?
<input type="radio"/>	<input type="radio"/>	Surgery?	<input type="radio"/>	<input type="radio"/>	A pacemaker or internal defibrillator?
<input type="radio"/>	<input type="radio"/>	A blood clot (DVT or pulmonary embolism)?	<input type="radio"/>	<input type="radio"/>	Having surgery within 6 weeks of your flight?
<input type="radio"/>	<input type="radio"/>	Ear/sinus trouble?	<input type="radio"/>	<input type="radio"/>	Pregnant at the time of your flight?
<input type="radio"/>	<input type="radio"/>	Diabetes?	<input type="radio"/>	<input type="radio"/>	Use a CPAP device?
<input type="radio"/>	<input type="radio"/>	A persistent cough (lasting more than 2 weeks)?	<input type="radio"/>	<input type="radio"/>	Use inhalers and/or supplemental oxygen?
<input type="radio"/>	<input type="radio"/>	Seizures or fainting spells?	<input type="radio"/>	<input type="radio"/>	Take insulin?
<input type="radio"/>	<input type="radio"/>	Have you been medically rejected for military service?	<input type="radio"/>	<input type="radio"/>	Have you received treatment for drug/alcohol dependence?
<input type="radio"/>	<input type="radio"/>	Have you been medically denied insurance coverage?	<input type="radio"/>	<input type="radio"/>	Have you been medically advised not to fly?
<input type="radio"/>	<input type="radio"/>	Do you now, or have you received medical disability?	<input type="radio"/>	<input type="radio"/>	Have you been medically advised not to scuba dive?

**EXPLANATIONS:** If you answered "YES" to any of the above items, describe the condition and the approximate date of occurrence. Use additional pages if necessary.

SIGNATURE OF APPLICANT:	DATE:
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When complete, FAX form to: Gregg A. Bendrick, MD, MPH  
Chief Flight Surgeon/NASA Dryden Flight Research Center  
Phone: (661) 276-2258 FAX: (661) 276-2392