

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/YY):	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
		Do you use a cane or walker?			Are you intolerant to heat?
		Do you require any splints, braces, or prosthetics?			Are you intolerant to cold?
		Are you unable to climb a ladder without assistance?			Are you afraid of heights?
		Are you unable to climb 2 flights of stairs without difficulty?			Is your vision uncorrectable to at least 20/40 (i.e., DMV standards)?
		Are you unable to walk for 30 minutes without resting?			Are you incapable of wearing a tightly fitting respirator mask?
		Are you unable to lift and control a weight of 45 pounds?			Do you require hearing aids?
		Are you unable to jump safely from a 5-foot height?			Are you afraid of confined or small spaces?
		Do you need to go to the bathroom more than every 2 hours?			Do you have problems at high altitude (i.e., above 4000 feet)?
		Do you have urinary or fecal incontinence?			Any recent hospitalizations (last 3 months)?
		Any heart or lung problems?			Any open wounds/sores requiring a dressing?
		A stroke (CVA) or TIA?			A colostomy or indwelling catheter?
		Surgery?			A pacemaker or internal defibrillator?
		A blood clot (DVT or pulmonary embolism)?			Having surgery within 6 weeks of your flight?
		Ear/sinus trouble?			Pregnant at the time of your flight?
		Diabetes?			Use a CPAP device?
		A persistent cough (lasting more than 2 weeks)?			Use inhalers and/or supplemental oxygen?
		Seizures or fainting spells?			Take insulin?
		Have you been medically rejected for military service?			Have you received treatment for drug/alcohol dependence?
		Have you been medically denied insurance coverage?			Have you been medically advised not to fly?
		Do you now, or have you received medical disability?			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**