

Cabin Crew Initial Medical Assessment in Accordance with EU-OPS 1.995

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 <input type="checkbox"/> Female <input type="checkbox"/>	
Place and country of birth:		Nationality:			
Address:			GP Name:		
Postcode:			Address:		
Country:			Telephone No:		
Telephone No:					
Mobile No:					
Alcohol – state average weekly intake in units:			Do you currently use any medication? Yes <input type="checkbox"/> No <input type="checkbox"/>		M
Do you smoke tobacco? Never <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>			If YES, state name of medication, dose, date started and why		M
If no, date stopped:					Y
					Y
					Y

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		
Any form of heart or vascular disease or stroke			Epilepsy or seizure			Admission to hospital			High blood pressure		
High blood pressure			Dizziness, episode of fainting or unconsciousness for any reason			Illness or injury not otherwise specified			High cholesterol level		
Kidney stone or blood in urine			Neurological disorders			Skin disorder			Epilepsy		
Diabetes or hormone disorder			Psychiatric or psychological trouble of any sort			Disorder affecting strength or movement or arthritis			Mental illness		
									Diabetes		
									Tuberculosis		
									Allergy, asthma or eczema		
									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:**