



M.E.A. MEDICAL DEPARTMENT
CADET PILOTS MEDICAL SCREENING

Form-3

Name of Applicant Last First Middle

Date of Birth Day Month Year

Medical History

Have you ever had any history of:

- 1. Pneumonia, Pleurisy, Tuberculosis YES NO
2. Heart or Vascular problems, High Blood Pressure YES NO
3. Asthma, Hay fever (Allergical Rhinitis) YES NO
4. Sinusitis, Repeated Tonsillitis or Otitis YES NO
5. Gastric or Duodenal Ulcer, Jaundice, Malaria, Hernia YES NO
6. Kidney Stones, Albumine or Blood in Urine YES NO
7. Low Back Pain, Severe Wounds, Fractures YES NO
8. Mental disease, Epilepsy, Depression, Attempted Suicide YES NO
9. Loss of consciousness YES NO
10. Repeated episodes of alcoholism YES NO
11. Smoker or non Smoker YES NO
12. Drug use or addiction YES NO
13. Hearing or Ear problems, Motion Sickness (Dizziness) YES NO
14. Abnormal speech or stuttering YES NO
15. Eye or vision problems YES NO
16. LASIK or vision correction surgery YES NO
17. Admission to hospital, surgical operations if any YES NO
18. Congenital disease or sickness YES NO

If answer to any of above is YES, provide explanation on an additional paper.

Provide details of physical activity or exercise that you do regularly:

Chronic Medication: Type: Frequency

Family History

Father Alive Died Age Cause of Death
Mother Alive Died Age Cause of Death

Is there any history in the family of Mental Disease, Diabetes, High Blood Pressure, Dyslipidemia Myopia and other family disease

YES NO Explain

Medical Declaration

I hereby declare that all statements and answers made by me in this form are complete and true.

I give my consent to the MEA examining Medical Officer to communicate with any hospital or physician to verify above information which has attended me.

Date: Day Month Year

Doctor Name:

Applicant's Signature

Signature:

Stamp: