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 *	YES ☐	NO ☐	*Declaration & Obligation .
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 the above is YES, provide explanation on an additional paper.

Height _____ cms and **Weight _____ kgs**

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 done by myself in this form are complete and true.
In addition to the above, I pledge to refrain & to desist from smoking at all times in conformity with MEA's regulations.
Also, I undertake to give my wholly agreeable consent without any reservation or constraint of any sort to the MEA examining Medical Officer to communicate with any hospital or physician as to verify the above information which has been declared by myself.

Date: _____ Doctor Name: _____ _____
Day Month Year Applicant's Signature

Signature: _____

Stamp: _____