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: ______________