

***Headache/Migraine Investigation Report***

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| Applicant Name: |       | CAA Participant Number |       |
| Class(es) of Medical Certificate sought |
| Class 1 [ ]   | Class 2 [ ]   | Class 3 [ ]   |

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| ***History*** |
| Date of first attack |       | Date of the most recent attack |       |
| Number of headaches in the last year |       | How long does an attack last? |       |

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| ***Medication*** |
| For symptoms |       | For prevention |       |

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| ***Description of your headaches or other migraine symptoms and how they affect you*** *(in applicant’s own words)* | ***Pain headache intensity scale****(Applicant mark on line using “ l ”)* |
|       |  1 5 10(Mild) (Severe) |
|  | Yes | No | If yes, give details and degree of capacity |
| 1. Avoidance of routine activity
 | [ ]  | [ ]  |       |
| 1. Distraction
 | [ ]  | [ ]  |       |
| 1. Nausea
 | [ ]  | [ ]  |       |
| 1. Vomiting
 | [ ]  | [ ]  |       |
| 1. Photo / phonophobia (light, noise intolerance)
 | [ ]  | [ ]  |       |
| 1. Motor or sensory features
 | [ ]  | [ ]  |       |
| 1. Aura / visual symptoms
 | [ ]  | [ ]  |       |
| 1. Acute medical / hospital treatment needed
 | [ ]  | [ ]  |       |
| 1. Any other symptoms e.g. mood changes, sleep disturbance or hangover effects
 | [ ]  | [ ]  |       |

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| *Severity Criteria*   |
| **Distracting** Distracting (able to continue but may impair performance)[ ]   | **Major Distracting** Able to continue activity but performance is impaired[ ]   | **Incapacitating** Unable to continue routine activity[ ]   |

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|  | ***Predictability Factors*** |
| **Patterns** | Yes | No | N/A | If yes, give details and degree of capacity |
| 1. Premenstrual
 | [ ]  | [ ]  | [ ]  |       |
| 1. Contraceptive medication
 | [ ]  | [ ]  | [ ]  |       |
| 1. Hormonal medication
 | [ ]  | [ ]  | [ ]  |       |
| **Triggers** |
| 1. Foods
 | [ ]  | [ ]  |       |
| 1. Alcohol or other beverages
 | [ ]  | [ ]  |       |
| 1. Stress
 | [ ]  | [ ]  |       |
| 1. Other
 | [ ]  | [ ]  |       |

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| *Warning Signs (pain/vision/tingling etc)* |
| Any warning signs of the headache | [ ]  Yes | [ ]  No |
| How long before the attack? |       | Describe the warning |       |

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| ***Medical Examiner to complete*** *(assessment of headache/migraine symptoms and management)* |
| Management of symptoms | Management of triggers | Treatment management (if applicable) |
| [ ]  Excellent | [ ]  Excellent | [ ]  Excellent |
| [ ]  Good | [ ]  Good | [ ]  Good |
| [ ]  Sub Optimal  | [ ]  Sub Optimal | [ ]  Sub Optimal |

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| *Additional Information (please attach to this as available)*  |
| **GP notes** (required if obtainable)[ ]   | **Neurologist** [ ]   | **Special Eye Report**[ ]   | **Other** (please specify) [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Examiner’s Declaration**: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.      |
| Examiner Name |       |  |
| Signature |  | Date of Application |       |

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| ***Medical Examiner comments about aeromedical risks associated with headache/migraine*** |
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