Headache/Migraine Investigation Report

CIVIL AVIATION AUTHORITY OF NEW ZEALAND
Te Mana Rererangi Tūmatanui o Aotearoa

Applicant Name:		CAA Participant Number	

Class(es) of Medical Certificate sought

Class 1 ☐	Class 2 ☐	Class 3 ☐

History

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

Medication

For symptoms		For prevention	

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 " I ")

1 (Mild) 5 10 (Severe)

	Yes	No	If yes, give details and degree of capacity
1. Avoidance of routine activity	☐	☐	
2. Distraction	☐	☐	
3. Nausea	☐	☐	
4. Vomiting	☐	☐	
5. Photo / phonophobia (light, noise intolerance)	☐	☐	
6. Motor or sensory features	☐	☐	
7. Aura / visual symptoms	☐	☐	
8. Acute medical / hospital treatment needed	☐	☐	
9. Any other symptoms e.g. mood changes, sleep disturbance or hangover effects	☐	☐	

Severity Criteria

Distracting	**Major Distracting**	**Incapacitating**
Distracting (able to continue but may impair performance) ☐	Able to continue activity but performance is impaired ☐	Unable to continue routine activity ☐

Predictability Factors

Patterns	Yes	No	N/A	If yes, give details and degree of capacity
1. Premenstrual	☐	☐	☐	
2. Contraceptive medication	☐	☐	☐	
3. Hormonal medication	☐	☐	☐	
Triggers				
4. Foods	☐	☐		
5. Alcohol or other beverages	☐	☐		
6. Stress	☐	☐		
7. Other	☐	☐		

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

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

Additional Information *(please attach to this as available)*

GP notes (required if obtainable) ☐	**Neurologist** ☐	**Special Eye Report** ☐	**Other** (please specify) ☐

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	

Medical Examiner comments about aeromedical risks associated with headache/migraine