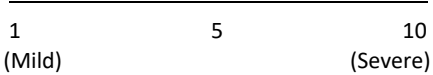


Headache/Migraine Investigation Report

Applicant Name:	<input type="text"/>	CAA Participant Number	<input type="text"/>
Class(es) of Medical Certificate sought			
Class 1	<input type="checkbox"/>	Class 2	<input type="checkbox"/>
		Class 3	<input type="checkbox"/>

History			
Date of first attack	<input type="text"/>	Date of the most recent attack	<input type="text"/>
Number of headaches in the last year	<input type="text"/>	How long does an attack last?	<input type="text"/>

Medication	
For symptoms	<input type="text"/>
For prevention	<input type="text"/>

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

Severity Criteria		
Distracting Distracting (able to continue but may impair performance) <input type="checkbox"/>	Major Distracting Able to continue activity but performance is impaired <input type="checkbox"/>	Incapacitating Unable to continue routine activity <input type="checkbox"/>

Predictability Factors				
Patterns	Yes	No	N/A	If yes, give details and degree of capacity
1. Premenstrual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Contraceptive medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Hormonal medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Triggers				
4. Foods	<input type="checkbox"/>	<input type="checkbox"/>		
5. Alcohol or other beverages	<input type="checkbox"/>	<input type="checkbox"/>		
6. Stress	<input type="checkbox"/>	<input type="checkbox"/>		
7. Other	<input type="checkbox"/>	<input type="checkbox"/>		

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)
<input type="checkbox"/> Excellent	<input type="checkbox"/> Excellent	<input type="checkbox"/> Excellent
<input type="checkbox"/> Good	<input type="checkbox"/> Good	<input type="checkbox"/> Good
<input type="checkbox"/> Sub Optimal	<input type="checkbox"/> Sub Optimal	<input type="checkbox"/> 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