

Headache Investigation Report
Medical in Confidence

1. APPLICANTS DETAILS (To be completed by the applicant)

| | | | | | | | | | |
|----------------------------------|------|--------------------------|-----|--------------------------|------------------------|--------------------------|-------------------|--|------------------------------------|
| Surname | | | | | Client No: (if issued) | | | | Rank or Title Mr, Mrs, Miss, Ms |
| | | | | | | | | | |
| Given names | | | | | | Place and date of birth | | | |
| | | | | | | |/...../..... | | |
| Postal Address: | | | | | | | | | |
| Class(es) of licence applied for | ATPL | <input type="checkbox"/> | PPL | <input type="checkbox"/> | ATCO | <input type="checkbox"/> | Other (specify) | | |
| | SCPL | <input type="checkbox"/> | SPL | <input type="checkbox"/> | | | | | |
| | CPL | | | | | | | | |

2. DURATION OF HISTORY

| | |
|----------------------------|--|
| Date of first attack | |
| Date of most recent attack | |
| Frequency of attacks | |

3. WARNING OF ATTACK

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| Any warning (aura or visual phenomena etc.)? | |
| How long before the attack? | |

4. DESCRIPTION OF ATTACKS (In applicant's own words)

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5. VISUAL DISTURBANCE

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| Give a detailed description of any visual disturbance, eg. Duration, nature, extent of visual field affected, time relationship to other symptoms | |
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6. HEADACHE

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| Describe headache and indicate severity | |
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7. INCAPACITY

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| State degree of incapacitation during an attack and whether accompanied by vomiting, muscular weakness or any other potentially incapacitating symptoms | |
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8. CONCENTRATION AND FINER JUDGEMENT

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| State whether these are likely to be adversely affected during an attack | NO/YES |
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9. DURATION OF ATTACK

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10. PREDICTABILITY

| | |
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| Is there a time of day when attacks always occur, or is this variable? | |
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11. WOMEN

| | |
|--|---------------|
| Are attacks likely to occur in association with menstrual periods? | YES/NO |
|--|---------------|

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|--|---------------|
| Are oral contraceptives being taken (If YES specify in Q14.) | YES/NO |
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12. STRESS

| | |
|--|---------------|
| Any relationship between stress of any kind and the onset of attacks? (If YES specify in Q18) | YES/NO |
|--|---------------|

13. PRECIPITATING FACTORS

| | |
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| Are there any other factors which appear to precipitate attacks? (eg food, drink) (If YES specify in Q17) | YES/NO |
|--|---------------|

14. MEDICATION

| | |
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| Is any Medication taken? Please specify For symptoms? YES/NO For prevention? YES/NO Describe effectiveness in alleviating/controlling symptoms | |
| Has prophylactic treatment been given at any time in the past, and, if so, with what results? | |

15. FAMILY HISTORY

| | |
|---|--|
| Is there any family history of migraine? (If YES please specify) YES/NO | |
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16. SPECIALIST INVESTIGATION

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| Has a Neurologist or Physician been involved in evaluation or treatment of the Migraine attacks? (Specify who and when) YES/NO | |
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17. OPINION

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| From the description of the attacks given, how likely is it that a recurrence while the applicant is flying would impair proper control of an aircraft Never <input type="checkbox"/> Rarely <input type="checkbox"/> Commonly <input type="checkbox"/> | |
| Taking into account the nature, frequency and severity of the attacks, do you feel that the applicant is fit for a <input type="text" value="Private/Professional"/> (delete as applicable) licence? | YES/NO |

18. OTHER RELEVANT INFORMATION

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|-----------------------|--|------|-------------------|---------|--|
| Signature of Examiner | | Date |/...../..... | Address | |
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