F/A-18 MEDICAL QUESTIONNAIRE

PRIVACY ACT STATEMENT

AUTHORITY: OPNAVINST 3710.7V, CNATRAINST 5357.1C, SORN N05726-1
PRINCIPAL PURPOSE: The purpose of this screening is to obtain medical data from applicants in order to aid in the determination of medical fitness for the Navy Flight Demonstration Squadron Backseat Rider Program with the U.S. Navy Blue Angels. The information collected will be used exclusively by the squadron's flight surgeon through the period of pre-vetting and flight to ensure guest riders are physically suited for participation in the program, and to assist in emergency medical care should the need arise.
ROUTINE USES: Those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, information contained will not be disclosed outside the DoD. This screening sheet will be destroyed at the end of the annual air show season.
DISCLOSURE: Disclosure is voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to the Navy Flight Demonstration Squadron Backseat Rider Program with the U.S. Navy Blue Angels.

Additional information can be found here: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570367/n05726-1/

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, OMB 0703-0073, is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

1. Name:		2. Day/Work Phone Number:			
3. City of Flight:	4. Date of Flight:	5. Age:	6. Height:	7. Weight:	8. Jacket Size:

9. Past Medical/Surgical History:

10. Do you have now, or have you ever had:

Yes	No	Question
		a. Disease of the eyes, ears, sinuses or seasonal allergies which still require medication?
		b. Difficulty clearing your ears or pain in your ears or sinuses from flying or scuba diving?
		c. Chest pain, angina, heart attack, heart disease, high blood pressure, heart murmur, palpitations, cardiac catheterization, pacemaker, or cardiac stress test?
		d. Stroke, phlebitis, blood clots in legs, excessive fatigue with mild exertion?
		e. Asthma, wheezing, emphysema, chronic cough, tuberculosis, collapsed lung, chest surgery of any kind, chest tube placed, or abnormal chest X-ray?
		f. Disease of the bowel, gastric ulcer, rectal bleeding, chronic abdominal or pelvic pain, hernia, kidney stone, disease of the urinary tract?
		g. Arthritis, joint deformity, limited movement of any joint, chronic neck or back pain, neck or back surgery, `slipped' or herniated disk, neurological surgery of any kind?
		h. Paralysis, muscle weakness, seizures, epilepsy, loss of consciousness or amnesia?
		i. Mania, depression, schizophrenia, panic attacks, fear of flying or fear of enclosed spaces?
		j. Anemia, sickle cell crisis, diabetes, liver or thyroid disease?
		k. Arterial gas embolism, decompression sickness or the `bends'?
		l. Are you currently pregnant or planning to become pregnant prior to the flight?
		m. Do you have any acute or chronic condition not listed previously? Please explain.
		n. Are you currently under care or therapy of a physician or practitioner for any medical condition? Please explain.
		o. Are you currently taking any medications? List.
		p. Difficulty jogging two (2) miles in 20 minutes or swimming 100 yards?

11. If you answered "yes" to any of the above questions (10a through 10p), please give details below and indicate if the condition is resolved:

I certify that the above information is true and correct and understand that I am required to have a physical examination by my family physician, at my own expense, prior to flying with the Blue Angels.

12. Applicant:	a. Printed Name:	b. Signature:	c. Date:

The following is to be completed by your examining physician:

13. The above patient was evaluated on (*date of exam*):

14. Please select one of the following:
- ☐ He/she has no medical contraindication for flight in a high performance aircraft with the Blue Angels.
- ☐ He/she has a medical condition(s), which may contraindicate a flight in a high performance aircraft.

15. Please list and explain all conditions and medications:

16. Examiner:

a. Printed Name & Credentials (*i.e., MD, DO, PA, NP)*:	b. Signature:	c. Date:	d. Phone Number:

17. Blue Angels Flight Surgeon:

a. Printed Name:	b. Signature:	c. Date:	☐ Approved ☐ Disapproved