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FAA TESTING: BACKGROUND INFORMATION FORM

Name:

Date of Birth: **Age**: **Handedness**: **Race**
Are you bilingual? **If bilingual, what is your preferred language**?
Marital Status: Choose an item.

FOR PILOTS
Medical Class: **License Type**: **Rating:**
Aircraft: **If relevant, enter airline with which you are employed**
Approx hours logged

REFERRAL OR REFERRAL SOURCE
Name of AME
Do you have an FAA letter requesting eval? **Name of Referring organization**

Briefly, what is the purpose of the testing:

If testing is for special medical issuance, what is the reason?

Have you had a special issuance in the past?
Have you previously taken CogScreen or other aviation related psychological or neuropsychological testing?

What were the events that led up to this current evaluation?

EDUCATIONAL HISTORY
High School Graduate? **If not, last grade completed?** **GED?**
Did you attend trade or vocational school? **If so, what type**?
My typical HS grades were:
Were you diagnosed with a learning disorder or ADD/ADHD/Hyperactivity?
Even if not diagnosed as above, did you have any particular difficulties with reading, spelling, math, or writing when you were in school?

College: Did you graduate from college? **If yes, level of degree:**
I**f you attended, but did not graduate, how many years did you complete**?
Name of College or University:
Major:
Typical grades in college:

Post-Graduate Education: If you attended an advanced or professional degree, complete the following

Degree:
Name of School/College/University:
Major:

MILITARY HISTORY: Have you served in the military?If yes, what branch, for how long, what rank, discharge status, etc.

Were you a pilot in the military?

OCCUPATIONAL HISTORY: Current employment status:
Do you have aviation employment plans or aspirations?
If currently employed: Job Title and description:

Place of employment:
How long have you worked there?

If retired: At what age did you retire?
What was your job title and description?

Where did you work?
For how long?

If unemployed, describe status, length, previous employment, or other relevant details

MEDICAL HISTORY:
Do you wear eye glasses? Do you have vision problems uncorrected by lenses?
Are you color blind?
Do you have hearing problems? Do you wear hearing aids?
Do you have tinnitus (ringing in your ears?)
Do you have any loss of smell or taste?

List and describe any previous surgeries, type of surgery and year done:

Please list all current medications, along with doses:

Indicate yes or no if you have had any of the following medical problems diagnosed by a doctor:

Head injury (incl, concussion):	Cerebrovascular disease (e.g., stroke, TIA):
Epilepsy or other seizures:	Episodes of syncope (fainting):
Brain Tumor:	Heart problems:
Multiple Sclerosis:	Hydrocephalus:
Hypertension (high blood pressures)	Diabetes:
Peripheral Neuropathy:	Cancer:
Blood Disorder (sickle cell, anemia, Hemophilia)	
Liver Disease (cirrhosis, hepatitis, etc)	Kidney disease or renal failures

Breathing Problems (COPD, emphysema, asthma)
Gastrointestinal problems (ulcers, IBS, GERD, colitis, Crohn's)
Heart problems (angina, heart attacks, mitral valve prolapse, congestive heart failure, coronary artery disease, etc)
Thyroid problems (hypo or hyperthyroidism)
High Cholesterol
Sleep problems (sleep apnea, insomnia, etc)
Immune Disorders, including HIV, AIDS
Other problems not listed, above

If any are checked "yes", please describe briefly:

MENTAL HEALTH HISTORY
Have you ever been diagnosed with any of the following?

Depression:	PTSD:	Dysthymic Disorder
Adjustment Disorder:	Bipolar Disorder:	Psychosis:
Schizophrenia:	Schizoaffective d/o:	Personality Disorder
Phobias:	Panic Attacks:	Neurosis:
Obsessive-Compulsive Disorder:	Any other psychiatric/psychological Diagnoses?:	

If yes, to any above, please describe:

Have you ever been hospitalized for a psychiatric condition?
If so, please describe:

Have you ever taken Psychiatric medication?
If so, please list medications and doses:

Are you currently taking psychiatric medication?
If so, please list medications and doses:

ALCOHOL AND SUBSTANCE ABUSE HISTORY
Do you currently drink alcohol?
If yes, how many drinks in a typical week?

Have you ever been diagnoses with or treated for any of the following?
Alcohol abuse
Alcohol Dependence
Substance abuse
Substance Dependence

Have you ever been charged with DWI, DUI, or public intoxication?

LEGAL HISTORY
Have you ever been arrested or convicted of a criminal offense?