# MAKI MD RESTORATION MEDICINE AVIATION MEDICAL PATIENT INTAKE

**PLEASE PRINT CLEARLY** DATE:______________________

PATIENT NAME: LAST NAME____________________________FIRST __________________________________
PREFERRED TO BE CALLED:______________________COMPANY NAME: ______________________________

STREET ADDRESS:_____________________________________________________________________________

CITY:__________________________________________ STATE:___________ ZIP_________________________

PRIMARY EMAIL: _____________________________________________________________________________

PHONE #S: C/H/W_____________________________ OTHER: C/H/W _________________________________

DOB:_______________________________________AGE: __________ SSN# __________-________-__________

MEDEXPRESS CONFIRMATION #: ___________________________________________________________________

PHYSICAL CLASS: ___1/ ___2/ ___3 NEED EKG? ___Y/ ___N

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DO YOU HAVE A STATEMENT OF DEMONSTRATED ABILITY (SODA)? ___Y/ ___N
IF YES: SODAY SERIAL #:________________________________________________________

DO YOU HAVE A SPECIAL ISSUANCE? ___Y/ ___N IF YES, PLEASE CLARIFY. DO YOU HAVE THE NECESSARY SUPPORTING DOCUMENTATION WITH YOU? ____Y /___N

______________________________________________________________________________________________

______________________________________________________________________________________________

DO YOU HAVE A CACI? ___Y/ ___N IF YES, PLEASE CLARIFY. DO YOU HAVE THE NECESSARY SUPPORTING DOCUMENTATION WITH YOU? ____Y /___N

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

DO YOU HAVE ANY MEDICAL CONDITIONS OR ADDITIONAL MEDICATIONS SINCE YOUR LAST FAA PHYSICAL? ____Y /___N IF YES, PLEASE CLARIFY.

______________________________________________________________________________________________

______________________________________________________________________________________________

DO YOU CURRENTLY USE ANY MEDICATION (PRESCRIPTION OR NONPRESCRIPTION? ____Y /___N
IF YES, PLEASE CLARIFY. MEDICATION, DOSAGE, FREQUENCY, & REASON

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

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HAVE YOU BEEN OR ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING?:

____ARTHRITIS

____ASTHMA

____ARTERIAL FIBRILLATION

____BLADDER CANCER

____BREAST CANCER

____(C-ITP) CHRONIC IMMUNE THROMBOCYTOPENIA

____CHRONIC KIDNEY DISEASE

____CHRONIC LYMPHOCYTIC LEUKEMIA

____CHRONIC OBSTRUCTIVE PULMONARY DISEASE

____COLITIS

____COLON CANCER

____DEEP VENOUS THROMBOSIS (DVT), PULMONARY EMBOLISM (PE), AND/OR HYPERCOAGULOPATHIES

____GLAUCOMA

____HEPATITIS C – CHRONIC OR OTHER

____HYPERTENSION

____HYPOTHYROIDISM

____ LYMPHOMA AND HODGKIN'S DISEASE

____ MELANOMA

____RETAINED KIDNEY STONE(S)

____MIGRANE AND CHRONIC HEADACHE

____ MIITRAL AND AORTIC INSUFFICIENCY

____MITRAL VALVE REPAIR

____ PAROXYSMAL ATRIAL TACHYCARDIA

____PRE-DIABETES

____PROSTATE CANCER

____PSORIASIS

____ RENAL CALCULI

____RENAL CANCER

____ SLEEP APNEA

____TESTICULAR CANCER

____THROMBOCYTOPENIA

DO YOU EVER USE CONTACT LENSES WHILE FLYING? ____Y /___N
IF YES, ARE THEY FOR: _____NEAR_____FAR ____BOTH

DO YOU EVER USE NEAR VISION "CHEATERS" WHILE FLYING? ____Y /___N

DO YOU WEAR PRESCRIPTION GLASSES WHILE FLYING? ____Y /___N
IF YES, ARE THEY FOR: _____NEAR_____FAR ____BOTH

HAS YOUR VISION BEEN SURGICALLY CORRECTED? ____Y /___N WHEN: ____/____/____ IF YES, PLEASE CLARIFY. ________________________________________________________________
________________________________________________________________________________

HAVE YOU EVER BEEN TESTED FOR COLOR BLINDNESS? ____Y /___N IF YES, _____PASSED_____FAILED

WHAT IS YOUR HEIGHT IN INCHES? ______INCHES WHAT IS YOUR TYPICAL WEIGHT? ________LBS

PATIENT EXAM WORK SHEET:

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PATIENT NAME: ______________________________________________________DATE:__________________

| HT: | INCHES | WT: | LBS | BMI: | |
|---|---|---|---|---|---|

| URINE: | NORMAL/TRACE/ETC | COMMENT: |
|---|---|---|
| SP GRAVITY | | |
| KETONES | | |
| PROTEIN | | |
| GLUCOSE | | |

VISION:

| **DISTANT:** | | CORRECTEDTO 20/20 CL 1,2 20/40 CL 3 | COMMENT: MISSED # |
|---|---|---|---|
| RIGHT | 20/ | 20/ | |
| LEFT | 20/ | 20/ | |
| BOTH | 20/ | 20/ | |
| **NEAR** | 16” | CORRECTED TO: 20/40 MIN EACH EYE SEP CL 1,2,3 | COMMENT: MISSED # |
| RIGHT | 20/ | 20/ | |
| LEFT | 20/ | 20/ | |
| BOTH | 20/ | 20/ | |
| **INTERM** | 32” | CORRECTEDTO: 20/40 MIN EACH EYE SEP CL 1,2 50+ | COMMENT: MISSED # |
| RIGHT | 20/ | 20/ | |
| LEFT | 20/ | 20/ | |
| BOTH | 20/ | 20/ | |
| COLOR BLIND | Y/N | | COMMENT: MISSED # |

| BLOOD PRESSURE | | MAX 155/95 COMMENT: |
|---|---|---|
| PULSE | | |
| TEMP | | |
| % OXYGEN | | |

| EKG: | | AT 35, & ANNUALLY AFTER 40 CL 1 ONLY |
|---|---|---|

NOTES: