***Headache Investigation Report***
***Medical in Confidence***

Civil Aviation Safety Authority of Papua New Guinea

## 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 ☐ SCPL ☐ CPL | PPL ☐ SPL ☐ | ATCO ☐ Other (specify) |

## 2. DURATION OF HISTORY

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

## 3. WARNING OF ATTACK

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

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

| |
|---|
| |

## 5. VISUAL DISTURBANCE

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

## 6. HEADACHE

| | |
|---|---|
| Describe headache and indicate severity | |

## 7. INCAPACITY

| | |
|---|---|
| State degree of incapacitation during an attack and whether accompanied by vomiting, muscular weakness or any other potentially incapacitating symptoms | |

## 8. CONCENTRATION AND FINER JUDGEMENT

| State whether these are likely to be adversley affected during an attack | **NO/YES** |
|---|---|

## 9. DURATION OF ATTACK

| |
|---|
| |

## 10. PREDICTABILITY

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

## 11. WOMEN

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

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

## 12. STRESS

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

## 13. PRECIPITATING FACTORS

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

## 14. MEDICATION

| | |
|---|---|
| Is any Medication taken? Please specify<br>For symptoms? **YES/NO**<br>For prevention? **YES/NO**<br>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** | |

## 16. SPECIALIST INVESTIGATION

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

## 17. OPINION

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 ☐ Rarely ☐ Commonly ☐

Taking into account the nature, frequency and severity of the attacks, do you feel that the applicant is fit for a Private/Professional (delete as applicable) licence? **YES/NO**

## 18. OTHER RELEVANT INFORMATION

| |
|---|
| |

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