

**RECREATIONAL AVIATION AUSTRALIA  
INC**

ABN 40 070 931 645  
Suite 3 / 1 Pirie Street  
PO Box 1265, Fyshwick ACT 2609  
Ph: 02 6280 4700 Fax: 02 6280 4775  
Website: [www.raa.asn.au](http://www.raa.asn.au)



RECREATIONAL AVIATION AUSTRALIA INC

**Medical Questionnaire and Examination Form**

Applicant to complete this page  
PLEASE PRINT

**SECTION 1**

Title: Mr Mrs Ms Other

Date of birth / /19  
(dd/mm/yy)

Family name .....

Given names ..... Age .....years

Member Number ..... Sex M F

Former name .....

Residential address (**Mandatory requirement**)

**Contact phone numbers**  
STD After hours

.....

Suburb ..... STD Working hours

State/Country .....

Postcode .....

Postal address ..... Total flying hours  
(leave blank unless different from residential) (to nearest hour) .....

Suburb ..... Hours flown in the  
last six months .....

State/Country .....

Postcode .....

Employer (professional aircrew only)  
.....

**Date of the last Australian Civil Aviation Medical/RA-Aus Examination (dd/mm/yy) / /**

**Applicant's usual Medical Practitioner and Dentist**

**Practitioner:** Name .....

Town .....State .....Phone No .....

**Dentist:** Name .....

Town .....State .....Phone No .....

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**SECTION 2: Examining Doctor's Information**

EXAMINER'S SURNAME ..... INITIALS .....

ADDRESS .....

DATE OF EXAMINATION .....

**SECTION 3: Aviation Information (please tick)**

**Standard 2**

Private Pilot/RA-Aus Instructor .....

.....  
Category of aircraft the applicant intends to operate

**Powered**

**Fixed-Wing – 3 Axis**

**Powered**

**Weightshift – Powered Parachute**  
– Weightshift Microlight

**SECTION 4: Health Questionnaire (please use black pen)**

*Since the last aviation medical examination, or in the last two years, has the applicant:*

- |  |     |                |
|--|-----|----------------|
| 1. been admitted to a hospital or suffered from any medical condition which may affect his/her ability to exercise the privileges of his/her licence?                                  | Y   | N              |
| 2. Suffered any chest or abdominal pain?   | Y   | N              |
| 3. Suffered any pain severe enough to be disabling?  | Y   | N              |
| 4. Coughed or vomited blood?   | Y   | N              |
| 5. Passed blood with urine or faeces?  | Y   | N              |
| 6. Taken any medically prescribed drugs for longer than two consecutive weeks?   | Y   | N              |
| 7. Had any traffic or criminal convictions relating to drugs or alcohol?   | Y   | N              |
| 7A. EVER, or is he/she NOW using any of the following substances: opiates, cannabinoids, sedatives and hypnotics, cocaine, other psychostimulants, hallucinogens or volatile solvents? | Y   | N              |
| 8. Had a laboratory test for HIV infection?  | Y   | N              |
| If yes, what was the result?   | +ve | -ve            |
| 9. Smoked tobacco in any form?   | Y   | N              |
| if cigarettes, state number per day.   | <10 | 10-25      >25 |
| 10. Undertaken exercise for at least 3 times per week for 20 minutes or more?  | Y   | N              |
| 11. Is there any significant family cardiac history?   | Y   | N              |

**SECTION 5A: Medical Examination**

1. Height (to nearest centimetre) ..... cm ..... Weight (to nearest kilogram) .....Kg  
 In all cases state the Body Mass Index.  
 (BMI = weight (kg)/height .....  
 Is the Body Mass Index **outside** the range 17.0 – 35.0? Y    N
  
2. In all cases, state the pulse rate  
 Pulse rate: mark appropriate range box <45 45-120 >120  
 Is there any abnormality in the pulse rhythm? Y    N
  
3. Blood pressure:  
 Is the blood pressure **outside** of acceptable limits (150/90)? Y    N  
 State the blood pressure .....
  
4. Is there any abnormality in the cardiovascular system including heart sounds, peripheral vasculature and perfusion? Y    N
  
5. Is anti-hypertensive therapy being used? Y    N  
 If yes, state medication and dose. ....

**SECTION 5B: Vision**

**Distance Vision Standard                      Class 2**

6. Does the applicant require visual correction for distant vision? Y    N  
 If yes, type of correction used:  
 spectacles                      soft contact lenses                      hard or gas permeable contact lenses
  
7. Distance vision acuity using a standard Snellen chart at 6 metres:  
**Without correction:**  

Right eye	6/5	6/6	6/9	6/12	worse than 6/12
Left eye	6/5	6/6	6/9	6/12	worse than 6/12
Binocular	6/5	6/6	6/9	6/12	worse than 6/12

 State visual acuity if worse than 6/12  

Right eye	Left eye	Binocular
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