

U.S. COAST GUARD AUXILIARY
AIR CREW MEDICAL SCREENING

Date _____

Applicant Name _____ Auxiliary Number _____

Date of Birth _____

NOTE TO APPLICANT: AFTER COMPLETION OF THE MEDICAL SCREENING
PLEASE FORWARD TO THE DIRECTOR OF AUXILIARY

Note to physician. Please examine the member in each category below and place an
"X" in the appropriate box. Explain any "**No**" answers on the reverse under **Comments**.
Sign the form attesting to your findings and return the completed form to the examinee.



Yes No

Distant Vision -- 20/40 or better in each eye with or without correction.

Near Vision -- 20/40 or better in each eye at 16 inches.

Color Vision -- Able to discern Red, Green, & Yellow.

Hearing -- Hearing average conversational voice in a quiet room
Using both ears at 6 feet, with the back turned to the examiner or
pass the audiometric test below.

Audiometry -- Pure tone audiometric test: Unaided, no worse than:

	<u>500HZ</u>	<u>1,000HZ</u>	<u>2,000HZ</u>	<u>3,000HZ</u>		
Better Ear	35Db	30 Db	30 Db	40 Db	<input type="checkbox"/>	<input type="checkbox"/>
Worst Ear	35 Db	50 Db	50 Db	60 Db		

ENT -- Absence of any ear condition manifested by vertigo or a
disturbance of speech or equilibrium

Pulse -- Normal

Blood Pressure -- Not over 155/95 with ___ or without ___ medication
Medication: _____

Mental -- Absence of psychosis, bipolar disorder, or severe
personality disorders.

Substance Dependence and Substance Abuse -- Is there an absence of a diagnosis of substance dependence or established evidence of recovery, including total abstinence from the substance(s) for not less than the preceding 2 years.

("Substance" includes alcohol, PCP, sedatives, hypnotics, anxiolytics, marijuana, cocaine, opioids, amphetamines, hallucinogens, and other psychoactive drugs and chemicals.) Yes No

Disqualifying Conditions -- History of: Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Diabetes Mellitus requiring medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Angina Pectoris | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Coronary heart disease being treated, is symptomatic or clinically significant. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Myocardial Infarction | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cardiac Valve Replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Permanent Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Heart Replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Disturbance of Consciousness
(without satisfactory explanation of cause) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Transient Loss of Nervous System Functions
(without satisfactory explanation of cause) | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

Signed _____ M.D./D.O.

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____