Comprehensive Medical Examination Checklist

BASICMED SECTION 2: INDIVIDUAL INFORMATION

(To be completed by the airman)

OMB Control Number: 2120-0770
Expiration Date: 06/30/2026

1-2	Omitted				
3	Name: Last:	First:	Middle:	4	SS # (optional)
5	Address/street:				Telephone:
	City	State/Country			Zip Code:
6.	Date of birth:	Country of Citizenship:			
7	Color of hair:	8 Color of eyes:		9	Sex:
10	Type of airman certificate(s) you hold:	□ Airline Transport □ ATC Specialist □ Commercial □ Flight Engineer □ Flight Instructor □ Flight Navigator □ Private □ Recreational □ Student □ None □ Other _____			
11	Occupation (optional):		12 Employer (optional):		
13	Has your FAA Airman Medical Certificate ever been denied, suspended, revoked, or withdrawn?	□ No □Yes If yes, give date _____ MM/YYYY			14. Omitted 15. Omitted
16	Date of Last FAA Medical Application	_____ MM/YYYY or □ No Prior Application (If no prior application, STOP. You cannot use BasicMed.)			
17	Do You Currently Use Any Medication? (Prescription or over-the-counter) **If additional space is needed, check this box ☐** **and list information on an additional sheet of paper**	□ No □Yes (If yes, list medication(s) and dosage used below.) Medication Name Dosage			
17b.	Do you ever use near vision contact lens(es) while flying	□ No □Yes Answer "Yes" if you wear a contact in one eye only to correct for near vision or if you have one contact that adjusts for near vision and one in the other eye that adjusts for distant vision.			

18 Medical History: Mark "Yes" if you have or had any of the following conditions at ANY TIME in your life. Explain when it occurred, the severity, how it was treated, and if you are currently taking any medication or having treatment for the condition or have to see a physician for the condition. Discuss any "Yes" responses with the physician doing this exam.

		No	Yes	**Additional comments or explanations (Give details in the space below)**
a.	Frequent or severe headaches:			
b.	Dizziness or fainting spell:			
c.	Unconsciousness for any reason:			
d.	Eye or vision trouble (except for glasses):			
e.	Hay fever or allergy:			
f.	Asthma or lung disease:			
g.	Heart or vascular trouble:			
h.	High or low blood pressure:			
i.	Stomach, liver, or intestinal trouble:			
j.	Kidney stone or blood in urine:			
k.	Diabetes:			
l.	Neurological disorders (epilepsy, seizures, stroke, paralysis, etc.):			
		No	Yes	

Comprehensive Medical Examination Checklist

m.	Mental disorders of any sort (depression, anxiety, etc.):	☐	☐
n.	Substance dependence, failed a drug test ever, or substance abuse or use of illegal substance in the last 2 years:	☐	☐
o.	Alcohol dependence or abuse:	☐	☐
p.	Suicide attempt:	☐	☐
q.	Motion sickness requiring medication:	☐	☐
r.	Military medical discharge:	☐	☐
s.	Medical rejection by military service:	☐	☐
t.	Rejection for life or health insurance:	☐	☐
u.	Admitted to a hospital:	☐	☐
x.	Other illness, disability, or surgery:	☐	☐
v.	History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug; or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program:	☐	☐
w.	History of non-traffic conviction(s) (misdemeanors or felonies): (e.g. battery, assault, public intoxication, robbery, etc.)	☐	☐

19.	Any visits to a health professional within the last 3 years? ☐ No ☐ Yes If "Yes," list the date, name, address, type of provider and why you saw them. If additional space is needed, check this box ☐ and list information on an additional sheet of paper	**Date**	**Name**	**Address**	**Type of Provider**	**Reason**

Airman's Signature and Declarations

In accordance with section 2307(b)(2)(A) of the FAA Extension, Safety, and Security Act of 2016 (Public Law 114-190), I affirm that:

☐ The answers provided by me on this checklist, including my answers regarding my medical history, are true and complete;

☐ I understand that I am prohibited under Federal Aviation Administration regulations from acting as pilot in command, or in any other capacity as a required flight crewmember, if I know or have reason to know of any medical deficiency or medically disqualifying condition that would make me unable to operate the aircraft in a safe manner; and

☐ I am aware of the regulations pertaining to the prohibition on operations during medical deficiency and I have no medically disqualifying conditions in accordance with applicable law.

Printed Name **Airman Signature**

NOTE: You must provide ALL sections (SECTION 1-3) of this checklist to your state-licensed physician who will perform and complete the comprehensive medical examination as required by Section 2307(a)(7) of FESSA.