

***Headache/Migraine Investigation Report***

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| Applicant Name: |  | | CAA Participant Number | |  |
| Class(es) of Medical Certificate sought | | | | | |
| Class 1 | | Class 2 | | Class 3 | |

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| ***History*** | | | |
| Date of first attack |  | Date of the most recent attack |  |
| Number of headaches in the last year |  | How long does an attack last? |  |

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| ***Medication*** | | | |
| For symptoms |  | For prevention |  |

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| ***Description of your headaches or other migraine symptoms and how they affect you*** *(in applicant’s own words)* | | | | ***Pain headache intensity scale*** *(Applicant mark on line using “ l ”)* |
|  | | | | 1 5 10  (Mild) (Severe) |
|  | Yes | No | If yes, give details and degree of capacity | |
| 1. Avoidance of routine activity |  |  |  | |
| 1. Distraction |  |  |  | |
| 1. Nausea |  |  |  | |
| 1. Vomiting |  |  |  | |
| 1. Photo / phonophobia (light, noise intolerance) |  |  |  | |
| 1. Motor or sensory features |  |  |  | |
| 1. Aura / visual symptoms |  |  |  | |
| 1. Acute medical / hospital treatment needed |  |  |  | |
| 1. Any other symptoms e.g. mood changes, sleep disturbance or hangover effects |  |  |  | |

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| *Severity Criteria* | | |
| **Distracting** Distracting (able to continue but may impair performance) | **Major Distracting** Able to continue activity but performance is impaired | **Incapacitating** Unable to continue routine activity |

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|  | ***Predictability Factors*** | | | | |
| **Patterns** | | Yes | No | N/A | If yes, give details and degree of capacity |
| 1. Premenstrual | |  |  |  |  |
| 1. Contraceptive medication | |  |  |  |  |
| 1. Hormonal medication | |  |  |  |  |
| **Triggers** | | | | | |
| 1. Foods | |  |  |  | |
| 1. Alcohol or other beverages | |  |  |  | |
| 1. Stress | |  |  |  | |
| 1. Other | |  |  |  | |

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| *Warning Signs (pain/vision/tingling etc)* | | | |
| Any warning signs of the headache | Yes | No | |
| How long before the attack? |  | Describe the warning |  |

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| ***Medical Examiner to complete*** *(assessment of headache/migraine symptoms and management)* | | |
| Management of symptoms | Management of triggers | Treatment management (if applicable) |
| Excellent | Excellent | Excellent |
| Good | Good | Good |
| Sub Optimal | Sub Optimal | Sub Optimal |

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| *Additional Information (please attach to this as available)* | | | |
| **GP notes** (required if obtainable) | **Neurologist** | **Special Eye Report** | **Other** (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Examiner’s Declaration**: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly. | | | |
| Examiner Name |  |  | |
| Signature |  | Date of Application |  |

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| ***Medical Examiner comments about aeromedical risks associated with headache/migraine*** |
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