UNITED STATES AIR FORCE SCHOOL OF AEROSPACE MEDICINE
Aeromedical Consult Services
Medical Flight Standards
Wright-Patterson Air Force Base, Dayton, Ohio 45433

Head Injury (Concussion) Questionnaire

Please provide all medical documents concerning this condition.	
Name:	SSN:
1. How did your head injury(s) occur?	
2. How old were you when each occured?	
3. Did you experience loss of consciousness? If yes, how long?	
4. Did you experience amnesia or confusion? If yes, how long?	
5. Were you treated at a hospital or by a physician? If so, what tests and/or what treatment were accomplished?	
6. Did you have any symptoms? If so, please explain. (e.g., headaches, vomiting, disorientation, double vision, dizziness, etc.)	
7. How long did your symptoms last after your injury, if applicable?	
8. List any other pertinent information you may have regarding your head injury.	
Please provide all emergency notes, clinical notes, evaluations, and radiology notes that pertain to the injury(s).	

By signing below, I certify that the above information is true and accurate to the best of my knowledge.

_____ _____

Applicant's Signature Date

Privacy Act Statement Authority: 5 USC §552a And Executive Order 9397**Purpose(s):** To determine medical acceptability or update a medical file as a part of the Flying Class I examination. **Routine uses:** This information may be disclosed to medical personnel engaged in the examination process. **Disclosure:** Voluntary; however, failure to furnish the requested information will impede the examination process and hamper your application. Use of Social Security Number (SSN) is used for positive identification of records.