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

Motion Sickness Questionnaire

Please provide all medical documents concerning this condition!	
Name:	SSN:
1. Describe the type of motion sickness (e.g., cars, trains, airplanes, boats, swings, carnival rides, etc	
2. What type of symptoms/reaction did you experience? (e.g., dizziness, nausea, vomiting, etc)	
3. At what age did this first occur?	
4. At what age did it last occur?	
5. Frequency of episodes? (e.g., 1 per month, 1 per week, daily, etc)	
6. What type of medication(s) and frequency do you use to prevent and/or treat your motion sickness?	
7. How would you rate the episodes, (e.g., mild, moderate, severe, etc.)?	
8. Does your motion sickness interfere with any activities?	
9. Provide any other pertinent information about your motion sickness.	

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.