



UNITED STATES AIR FORCE SCHOOL OF AEROSPACE MEDICINE

Aeromedical Consult Services

Medical Flight Standards

Wright Patterson Air Force Base, Dayton, Ohio 45433

Sleep Walking Questionnaire

Please provide all medical documents concerning this condition!	
Name:	SSN:
1. How frequent were the sleep walking episodes? daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/>	
2. Have you ever seen a medical provider for sleepwalking? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>If Yes, explain details:</i>	
3. When did you last sleep walk? (age, month & year)	
4. Please provide any pertinent information related to your sleep walking, such as special circumstances and who observed episodes:	

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.