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Dean Olson, MD
Senior/FAA Employee/HIMS AME

Arthritis Status Report Worksheet

Patient Name:____DOB::___________________________

Condition stable on current regimen and no changes in treatment recommended:
- ☐ Yes
- ☐ No

  If no, what recommended changes:____

Experienced no or mild to moderate symptoms with no significant limitations to range of motion, lifestyle, or activities?
- ☐ None
- ☐ Mild to Moderate
- ☐ Other, list limitations:____

Cause of Arthritis:
- ☐ Rheumatoid (limited to joint)
- ☐ Psoriatic
- ☐ Ankylosing Spondylitis
- ☐ Osteoarthritis
  - ○ Well controlled? Y N
  - ○ No functional limitations? Y N
  - ○ Treatment is PRN NASAIDS or anti-inflammatory meds only? Y N
- ☐ Other cause: ____

Medication(s) - One or more of the following (check all that apply):
- ☐ Oral steroid – equivalent dose does not exceed equivalent of prednisone 20 mg/day
- ☐ NSAIDS
- ☐ Methotrexate
- ☐ Hydroxychloroquine/Chloroquine (Plaquenil/Aralen) – Mandatory Eye Status Report required*
- ☐ Any of the following? – (only one medication below is allowed with required no-fly time after each use):
  - ☐ Adalimumab (Humira): 4-hour no-fly
  - ☐ Apremilast (Otezla): n/a
  - ☐ Etanercept (Enbrel): 4-hour no-fly
  - ☐ Infliximab (Remicade): 24-hour no-fly
  - ☐ Rituximab (Rituxan): 72-hour no fly
  - ☐ Secukinumab (Cosentyx): 4-hour no-fly
- ☐ Other:____

Labs:
- ☐ If no medications, NSAIDS, or steroids only, no labs required
- ☐ Normal CBC, LFT, and Creatinine within the last 90 days**

* Mandatory Eye Status Report included if needed for medication use.
** If labs are not normal, please provide a copy of the lab reports.

__________________________ __________________________ ________________
Treating Physician's Signature Physician's Printed Name Date

Expert FAA Medical Assistance!

Clinic Locations:
Wisconsin: 10520 W. Bluemound Rd, Suite 206
Milwaukee, WI 53226
Ohio: 7071 Corporate Way, Suite 105
Centerville, OH 45459

Mailing Address:
1817 Highland Dr. #1135
Grafton, WI 53024
Tel: 414-419-3300
Fax: 210-640-1938

HYDROXYCHLOROQUINE (HCQ)/ CHLOROQUINE (CQ) STATUS REPORT (Plaquenil/Aralen)

(Updated 09/29/2021)

Name ____ Date of Birth ________________________

MID#__________________ Applicant ID# ____________________ PI#_____________________

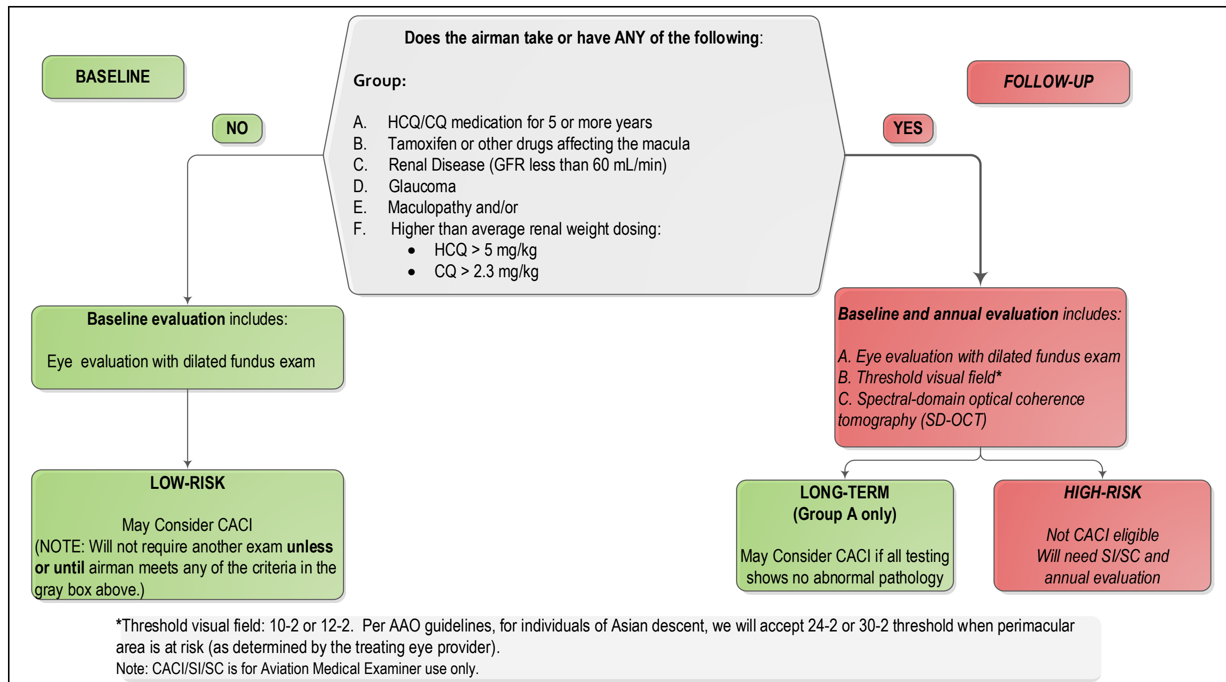
The treating ophthalmologist or optometrist must complete this status report. The Airman must provide this document and copies of all required tests (see below) to AME or directly to the FAA:

Using US Postal Service:
Federal Aviation Administration
Aerospace Medical Certification Division AAM-300
Mike Monroney Aeronautical Center
PO BOX 25082
Oklahoma City, OK 73125

OR

Using special mail (UPS, FedEx, etc.):
Federal Aviation Administration
Aerospace Medical Certification Division-AAM-300
Civil Aerospace Medical Institute, Building 13
6700 S. MacArthur Boulevard, Room 308
Oklahoma City, OK 73169

1. Provider printed name/title: __________________________ Phone number __________________
2. Date hydroxychloroquine (HCQ) or chloroquine (CQ) treatment initiated_______________________
3. Date of most recent HCQ/CQ screening ________________
4. Type of screening: ☐ **Baseline** or ☐ **Follow-up**



5. Evidence of bull's-eye lesion or other macular/extra-macular retinopathy: ☐ Yes ☐ No
   If yes, explain: ____
6. Abnormality on automated threshold visual field testing: ☐ Yes ☐ No
   If yes, explain: ____
7. Abnormality on Spectral-domain optical coherence tomography (SD-OCT): ☐ Yes ☐ No
   If yes, explain: ____
8. Any other eye pathology, symptoms, color vision loss, or clinical concerns? ☐ Yes ☐ No
   If yes, explain: ____

Treating Provider Signature ______________________________ Date ____________

Modified from 2016 American Academy of Ophthalmology (AAO) guideline recommendations