

## 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 NSAIDS 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 below 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:**

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Grafton, WI 53024  
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# PLAQUENIL STATUS REPORT

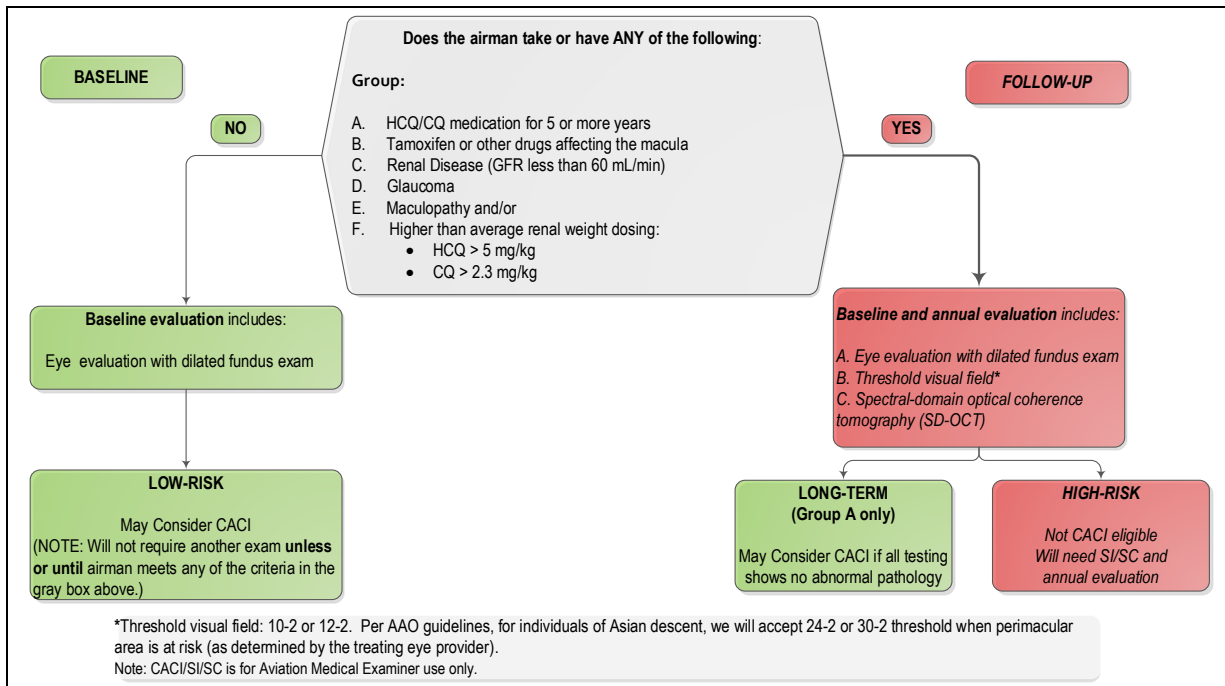
(Use for hydroxychloroquine/Aralen/chloroquine)  
(Updated 05/25/2022)

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:

<b>Using US Postal Service:</b> Federal Aviation Administration Aerospace Medical Certification Division AAM-300 Mike Monroney Aeronautical Center PO BOX 25082 Oklahoma City, OK 73125	<b>OR</b>	<b>Using special mail (UPS, FedEx, etc.):</b> 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
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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](#)