Mental Health History Checklist

(Updated 11/18/2026)

Name _____ Birthdate _____

Applicant ID# _____ PI# _____

Dear Doctor or Provider: Your patient is a pilot, Air Traffic Control Specialist, or applicant undergoing Federal Aviation Administration (FAA) medical certification/clearance. Following an **in-person** clinical evaluation and thorough record review, please complete the attached Mental Health History Checklist to highlight any clinical factors with safety implications. For any item marked "Yes," circle the corresponding symptom or diagnosis in that row.

Regardless of your checklist responses, attach a signed and dated clinical evaluation progress note. It must include a detailed mental health history, a formal diagnostic statement (or explicitly state "no diagnosis"), past and current medications with dosages, ongoing treatment recommendations, and an assessment of current mental status and overall functioning.

Submit the completed checklist, clinical notes, and relevant medical records directly from your office to the aviator's Aviation Medical Examiner (AME) or the FAA. FAA submissions must be mailed to: Federal Aviation Administration, Aerospace Medical Certification Division (AAM-300), P.O. Box 25082, Oklahoma City, OK 73125.

Most recent symptoms, diagnosis, or treatment (check most accurate response)
[ ] Never [ ] less than 2 years ago [ ] 2 to 5 years ago [ ] 5+ years ago Date: _____

1.	Any deficits in cognition, attention, concentration, memory, or processing speed?	No	Yes
2.	Have **active or unstable** psychiatric diagnoses/symptoms, **recurrent episodes** of psychiatric condition, or **poor insight** into their condition/treatment?	No	Yes
3.	**Past or present history** (diagnosis or symptoms) of: bipolar disorder, psychosis, a personality disorder, eating disorder, somatic disorder, or dissociative disorder?	No	Yes
4.	History of use of educational IEP or 504 plan for Mental Health or treatment with medication for ADHD within the last 4 years.	No	Yes
5.	Currently taking any mental health medications? If yes, have they changed the dose within the past 3 months? [ ] No [ ] Yes	No	Yes
6.	**Past or present history of taking** two or more psychiatric medications concurrently? *(Exclude medications used strictly for sleep or sexual side effects.)*	No	Yes
7.	**Past or present history** of: treatment with a mood stabilizer, antipsychotic, TMS, ECT, Ketamine, Esketamine, hallucinogen, or other therapy for treatment-resistant psychiatric conditions.	No	Yes
8.	**Past or present history** of: suicide attempt, self-harm behavior, psychiatric IOP/PHP or inpatient treatment, involuntary/court/administrative required evaluations hold or treatment.	No	Yes
9.	**Past or present history** of substance disorder symptoms: withdrawal, tolerance, inability to control use, continued use despite recurrent negative consequences of substance use; history of two DUI arrests; a positive occupational or legally requested substance test or a refusal or failure of such a test; a blood or breathalyzer alcohol level of .15% (150 mg/dL) or above.	No	Yes
10.	**Past or present history** of: any lifetime incarceration, more than 2 lifetime arrests, any criminal conviction (including misdemeanor or felony, even if expunged), current gambling disorder, behavioral addiction, or maladaptive personality traits.	No	Yes
11.	**Past or present history of**: stalking, abuse, assault, or violent behavior; or repeated falsification of information; or disregard for safety rules.	No	Yes

_____ _____
Treating Provider Signature Date of Evaluation

_____ _____
Print Name, Medical Credentials (e.g., MD, DO, PA-C, NP) Phone Number

AME Actions: Review above and any supporting documents. See corresponding disposition table.