TECHNICAL REPORT STANDARD TITLE PAGE

Report No.	2. Government Accession No.	3. Recipient's Catalog No.
FAA-AM-73-8		

Title and Subtitle

PREVALENCE AND INCIDENCE OF DISEASE AMONG AIRMEN MEDICALLY CERTIFIED DURING 1965

5. Report Date: April 1973

6. Performing Organization Code: AAC-132

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8. Performing Organization Report No.

Performing Organization Name and Address

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10. Work Unit No.

11. Contract or Grant No.

13. Type of Report and Period Covered

Sponsoring Agency Name and Address

Office of Aviation Medicine
Federal Aviation Administration
800 Independence Avenue, S.W.
Washington, D. C. 20591

14. Sponsoring Agency Code

Supplementary Notes

Abstract

This historical prospective study follows some 306,000 airmen medically certified ing 1965 through December 1969 to observe prevalence and incidence of disease ng these airmen. It also considers possible contribution of medical factors to rition of airmen from an active status as a follow-up to a previous FAA study cerning characteristics of airmen involved in attrition. The study provides ntification for questions concerning frequency of examination by age, incidence of nology in relation to frequency of examination, and a comparison of the attrition -group with the still active airmen sub-group with respect to prevalence, incidence, class of medical certificate issued. Basic descriptive epidemiologic data are o provided. Disease prevalence was highest for abdominal conditions among the al study group. Prevalence of disease from all categories was highest for the rition sub-group even though they were slightly younger than the still active sub-up. Frequency of examination was highest for the middle-aged applicants and cause-cific incidence of disease increased with frequency of examination up to a frequency approximately one examination per year. Abdominal and cardiovascular diseases resented the greatest incidence for the total study group and the still active -group. Miscellaneous conditions, i.e., skin diseases, endocrinopathies, allergies, general systemic conditions,were slightly more important among the attrition sub-up. Overall, the attrition sub-group demonstrated the highest prevalence and dence of disease for the study period. However, 86% of the attrition sub-group no recorded disease, thus diminishing the apparent importance of medical factors a primary motivator for attrition.

Key Words

rman Certification (Medical)
sease, Prevalence and Incidence
lots, Active and Attrition
atistical Analysis

18. Distribution Statement

Availability is unlimited. Document may be released to the National Technical Information Service, Springfield, Virginia 22151, for sale to the public.

Security Classif. (of this report)	20. Security Classif. (of this page)	21. No. of Pages	22. Price
Unclassified	Unclassified	22	$3.00

DOT F 1700.7 (8-69)

ACKNOWLEDGEMENT

The author wishes to express appreciation to Richard H. Rice of the Medical Statistical Section, Civil Aeromedical Institute, and Dr. Paul S. Anderson of the O. U. Medical School, Department of Biostatistics and Epidemiology, for their comments and suggestions. Appreciation is also extended to Shirley Dark and Judy Toberman for their assistance in data accumulation and preparation of this study.

PREVALENCE AND INCIDENCE OF DISEASE AMONG AIRMEN MEDICALLY CERTIFIED DURING 1965

I. Introduction

Approximately 332,000 examinations for FAA medical certification were performed during 1965 involving some 310,000 airman applicants (some airline pilots are examined semi-annually). From the total 310,000 airman applicants, 306,436 (99%) were medically certified during 1965. This historical prospective study follows those 306,436 certified airmen from 1965 to 1970 to observe prevalence of pathology at outset and the incidence of disease among these airmen during the study period. The study also considers possible contribution of medical factors to attrition of airmen from an active status as a follow-up to a previous FAA study[1] concerning characteristics of airmen involved in attrition.

In addition, the study was designed to provide quantification for questions concerning frequency of examination by age, incidence of pathology in relation to frequency of examination, and a comparison of the attrition sub-group with the still active airmen sub-group with respect to prevalence, incidence, and class of medical certificate issued. Underlying these areas of analytic interest was the need for basic descriptive epidemiologic data for current and future comparative use in appraisal of airman population health status and program policy monitoring.

II. Source, Definitions, and Methods

A. *Source and Definitions*

Automated medical record files maintained by the Aeromedical Certification facility in Oklahoma City provided the source data for the study. Automated historical files have been maintained since 1962 on records dating back to 1959 for all airman medical applicants. These files contain examination data for the individual airman, sequenced by date of examination.

The year 1965 was chosen as the beginning year for the study because of factors associated with system stabilization. Computer system implementation occurred during 1962, and prior to 1965, automated procedures, code schedules, and internal policies were subject to modification quite frequently in connection with post-implementation efforts. Some changes did, of course, occur during the study period with regard to policy on coding of disease conditions; however, the years 1965–1969 do represent the period of greatest stability for study purposes.

In this study, a medically certified airman is considered "active" for a maximum of 24 calendar months following his most recent FAA medical examination, i.e., regardless of the class of medical certificate originally issued, it is valid for third class airman purposes for a period of time up to 24 calendar months unless otherwise limited or recalled by the FAA. This definition results in sub-groups for presentation and discussion purposes consisting of the still active sub-group (those airmen medically certified during 1965 whose most recent examination was during 1968 or 1969) and the attrition sub-group (those airmen medically certified during 1965 whose most recent examination was during 1965–1967), which together comprise the total study group.

Much of the prevalence and incidence data contained in the tables which follow differentiates between critical and non-critical pathology. While many diseases are potentially critical in the mortality or morbidity sense, the Office of Aviation Medicine has identified several which are considered critical to the flight environment. The primary consideration in the FAA definition of "critical" pathology is related to potential of the disease for sudden incapacitation or inability to respond to the flight environment.

An extract listing of those medical conditions defined by FAA medical personnel as "critical" to the flight environment are provided in the appendix. A complete listing of medical conditions by code categories, as utilized by FAA certification personnel, is available from the author on request. Many of the listed diseases are, of course, critical regardless of the environment. Others may appear less critical in the classical sense; however, the unique FAA definition must be recalled.

Federal Aviation Regulations, Part 67, specify that a medical certificate will be denied if an applicant has an established medical history or clinical diagnosis of any of the following conditions:

1. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.
2. A psychosis.
3. Alcoholism.
4. Drug dependence.
5. Epilepsy.
6. Disturbance of consciousness without satisfactory medical explanation of the cause.
7. Myocardial infarction.
8. Angina pectoris or other evidence of coronary disease.
9. Diabetes mellitus, requiring insulin or other hypoglycemic drug for control.

However, certification is possible despite the existence of one of the above disqualifying medical conditions if exemption from the Regulations is granted after extensive medical review by the FAA and consultant specialists. The primary considerations in such exemption cases are history, prognosis, and potential risk of sudden incapacitation. From 1961 through 31 December 1972, a total of 1,051 airmen were granted exemptions from FAR 67 of which 454 are still active. It is appropriate to note, however, that airmen with any of the nine disqualifying conditions are often issued medical certificates with special medical and operational restrictions that allow for control of risk.

B. *Methods*

Initially, all applicants for medical certification during 1965 were selected for the study but those denied certification on the first examination were subsequently excluded since they would provide no possibility for follow-up experience. A remaining total of 306,436 airmen were medically certified at least once during 1965. Prevalence of pathology for the group was determined as of the first certified examination received. Incidence of disease and frequency of examination were based on examinations performed subsequent to the first examination in 1965 through 31 December 1969. Incidence, of course, was based on the occurrence during the study interval of disease other than that recorded on the initial examination (prevalence).

This study is not a classical cohort study of individuals entering an observation group and exposure category at a specified time and then being followed forward. Exposure categories are not defined as such and outcome is in terms of all disease incidence. No follow-up to determine causes for withdrawal was possible and the result is that one must deal with unknown biases as a result of loss to follow-up among those considered as attrition. Death, voluntary withdrawal for medical or personal reasons, economic factors, and disenchantment with aviation are known to be the major contributors to attrition.[1] Fortunately, as concerns this study, medical factors or death represent the least important reasons for attrition or loss to follow-up in terms of relative contribution.

Loss to follow-up is a reality which must be dealt with in most any cohort study. Theoretically, loss to follow-up will affect the relative rates for exposure categories only if it is suspected that bias exists with respect to exposure category and outcome. As mentioned previously, this study does not consider exposure categories in the classical sense, e.g., those that smoke versus those that do not smoke, etc. Outcome is measured in terms of incidence of some pathology during the study interval. Obviously, some of those lost to follow-up did develop pathology subsequent to their most recent examination; however, from previous study results,[1] it is felt that outcome bias is minimal for those lost to follow-up (or defined as attrition). Certainly, data obtained for those that did provide follow-up are valid with respect to outcome.

The person-years method for computing incidence rates was determined to be the most

appropriate method of dealing with the unknowns described above. Obviously, the most compelling reason for selection of this method is based on the observation that the study group did not retain the same numerical strength during the study period. Attrition from the observation group confounds the task of incidence computation, i.e., denominator definition, and does occur for varied reasons. The use of person-years as the denominator for incidence rate computations does not depend on the entire study group being present for the total study period, rather it takes into consideration the number of persons under observation and the duration of observation for each person.

MacMahon and Pugh suggest that "when follow-up depends on a regularly scheduled examination and ascertainment of the outcome depends on detecting a change in status between one examination and the next, the most accurate procedure is to assume that persons lost to trace between two examinations were lost immediately after the first examination." [2] The reason for such treatment of those lost to follow-up is obvious. Since they cannot possibly contribute to measured incidence during the interval, i.e., a positive outcome, they should not contribute to person-years observed past the date of most recent examination. Therefore, individuals lost to follow-up in this study are considered lost immediately after their most recent examination. Because entrance dates varied for study group members from 1 January 1965 to 31 December 1965, a mid-year entry date was selected as representative for subsequent computation of person-years. Applications are received in a consistent manner throughout the year, particularly as concerns the number received prior to mid-year versus those received after mid-year.

Table I provides information on the year of most recent examination for study group members and the method for computing person-years exposure.

Approximately 60% of the airmen in the original study group were still active (using the study definition of active airmen) as of the cut-off date (31 December 1969) and thus provided 700,752 person-years of observation. The total study group provided 778,266 person-years of observation; therefore, inactive airmen provided 77,514 person-years of observation.

Statistical significance at the .05 level was determined for total cause-specific and total age-specific rate differences on prevalence data and for total cause-specific rates on the incidence data (Tables II, III, IV, X, XI, and XII—the third cause-specific rate in the last column and the rate in the last row). Statistical significance was not determined for the cause/age-specific cell differences or critical/non-critical cause-specific or age-specific rates; however, trends are noted as appropriate. Methodology is described more fully in reference 3; however, the technique basically involves determination of the variance of the difference between two rates; and subsequently, the standard error which is divided into the difference between the two rates to arrive at a critical ratio, which is used to approximate the probability that the observed difference could have occurred due to chance. The formula is as follows:

$$CR = \frac{\text{Rate}_1\ (R_1) - \text{Rate}_2\ (R_2)}{\sqrt{\frac{R_1^2}{N_1\ (\text{Observed Cases Group 1})} + \frac{R_2^2}{N_2\ (\text{Observed Cases Group 2})}}}$$

Thus, if the difference between the two rates is statistically significant at the .05 level, CR is greater than or equal to 1.96. This methodology was also used to appraise successive rate differences for disease incidence by frequency of examination and for rate differences on most recent examination pathology status data. Potentially meaningful significance at levels other than .05 are noted as appropriate.

Prevalence rates are expressed per 1,000 airmen and incidence rates in terms of 10,000 person-years in order to present meaningful non-fractional rates for the latter. Rates were expressed per 1,000 airmen for incidence of disease in relation to frequency of examination data. Percentages were utilized for data dealing with most recent pathology status for convenience of comparison.

Data presented are descriptive in nature with numerous active versus attrition comparisons. Reference to table footnotes is recommended for further statements of methodology and data limitations.

III. Findings and Discussion

Some explanatory comments are appropriate before commencing a discussion of findings. Conventional epidemiologic terminology and definitions[4] apply to the discussion which follows. However, due to critical and non-critical categories within each body system, cause-specific rates are broken down into critical cause-specific, non-critical cause-specific, and total cause-specific rates. Age-specific and age/cause-specific cell frequencies are similarly broken down. Only total rates were, however, computed for age-specific and age/cause-specific cell data.

To reiterate, significance tests were performed on total cause- and age-specific rates only. While much useful information may be available from the multitude of possible within-category-significance comparisons, the interest in this study centers on the overall relationship of total prevalence and incidence and the resulting impact on attrition.

A. *Prevalence of Disease*

1. Prevalence of Disease Among All 1965 Certified Applicants (Table II). Total cause-specific prevalence was highest for abdominal (esophagus and stomach, intestines, spleen, liver, pancreas, gall bladder, and genitourinary and gynecological) disease (57.0 per 1,000 airmen); eye conditions were second highest (19.4 per 1,000 airmen). Age/cause-specific total prevalence was also highest for abdominal conditions (ranging from 21.9 to 139.6 per 1,000 airmen as age increases) except for persons less than 20 years old, for whom eye conditions and miscellaneous conditions (skin, drugs, endocrinopathies, allergies, and general systemic conditions) were highest (both rates were 22.3 per 1,000 airmen). Critical cause-specific pathology prevalence was highest for eye conditions for the total study group (11.1 per 1,000 airmen).

As expected, age/cause-specific prevalence generally increased with age, with the exceptions of neuropsychiatric and the miscellaneous conditions. Prevalence patterns for the latter conditions peaked earlier in the age distribution and tapered off as age increased. Total age-specific rates for all disease prevalence also increased with age (last row).

2. Prevalence of Disease for Airmen Still Active (Table III). Disease prevalence findings among airmen still active as of 31 December 1969 cut-off date for the study paralleled findings for the total study group. Some minor exceptions were noted in comparison of cell prevalence; however, cause-, age/cause-, and age-specific prevalence rates were comparable with respect to trend but lower than total study group prevalence rates. Table V contains summary rate data for the total study group and the still active and attrition sub-groups. Total cause-specific rate differences between the total study group and the airmen still active sub-group were significant except for ear, nose, throat and mouth disease which was not significant and muscle disease which was significant at the .10 level. Total age-specific rate differences were significant with the exception of age intervals greater than 55 years. Similar patterns were observed for these older age intervals; however, the limited number of observations resulted in statistical non-significance.

3. Prevalence of Disease Among Airmen Defined as Attrition (Table IV). Disease prevalence findings for the attrition sub-group paralleled findings for the total study group. Cause-, age/cause-, and age-specific rates were comparable with respect to trend but were higher than either the total study group prevalence rates or the airmen still active prevalence rates (see Table V). Total cause-specific rate differences between the total study group and the attrition sub-group were significant except for the ear, nose, throat and mouth disease category which was significant at .10 level. When attrition versus still actives were compared, both total cause-specific and total age-specific rate comparisons indicated significant differences for all but one age-specific category (greater than 65 years). Total age-specific rate differences for the total study group and the attrition sub-group were significant except for the less than 20 years interval. The 55–59 and 60–64 age intervals were significant at .10.

B. *Age and Frequency of Examination*

1. Age and Frequency of Examination for All 1965 Certified Applicants (Table VI). The mean age of all 1965 certified applicants selected for the study was 35.0 years. Median age was also approximately 35.0. Average frequency of examination for all study group members was 3.1 for the 5–year interval. Average frequency of examination by age approached symmetry

with the higher frequencies of examination in the middle age intervals. Mean age by frequency of examination was somewhat erratic with mean age exceeding the population mean age sporadically. It appears from Table VI that frequency of examination increases through the middle age range and decreases toward both age extremes for the total study group.

2. Age and Frequency of Examination for Airmen Still Active (Table VII). Airmen still active had a slightly higher mean age than the total study group (36.0 years). Median age was also approximately 36.0 years. Average frequency of examination for airmen still active was expectedly higher at 4.2 examinations for the 5 year interval. Similar patterns to the total study group were apparent for the distribution of airmen still active with respect to age and frequency of examination. It is interesting that prevalence rates were uniformly lower for the slightly older still active sub-group, since one would empirically expect higher prevalence of disease for an older group (see Table V).

3. Age and Frequency of Examination for Airmen Defined as Attrition (Table VIII). The mean age of airmen defined as attrition was lower at 33.7 years than for the total population or those airmen still active. Median age was approximately 33 years. Average frequency of examination for the attrition sub-group was lower at 1.4 for the study interval. No important differences from previously established distribution patterns were apparent with the exception of the magnitude of the variables.

C. *Incidence of Disease*

1. Incidence of Disease by Frequency of Examination (Table IX). Cause-specific incidence of disease generally increased with frequency of examination, up to frequency of 6–7 examinations, and began to decrease as frequency of examination increased beyond that point. Abdominal and muscle disease incidence continued to increase through the higher frequencies of examination. Miscellaneous disease conditions showed a reverse pattern with incidence decreasing for greater frequencies of examination. Incidence of all pathology was greatest for a frequency of 6 examinations. When successive rates within a body system are compared, differences are significant for all comparisons through the 6–7 frequency of examination level. Relatively speaking, ear, nose, throat and mouth pathology reflected the greatest increase with an increase in frequency of examination. However, more disease would be diagnosed in the abdominal and cardiovascular areas in absolute terms.

These data are most informative even though it is immediately apparent that much information has been obscured by the combinations of all classes and ages in Table IX. Age by frequency of examination as reflected in Tables VI through VIII does not suggest much in furtherance of the interpretation. One would presume that those with a greater frequency of examination (6−10+) were probably professional airmen who would have been screened more carefully and selectively prior to employment to minimize future health problems. Certainly, a detailed analysis of the age and class of medical certificate relationship is called for in future efforts.

2. Incidence of Disease Among All 1965 Certified Applicants (Table X). The total study group provided 778,266 person-years of observation. Using this total as the denominator for computation of incidence rates per 10,000 person-years of observation, the data contained in Table X was obtained. Total cause-specific incidence of disease was highest for abdominal conditions (115.4 per 10,000 person-years) among all 1965 applicants and second highest for cardiovascular pathology (62.2 per 10,000 person-years). Incidence of cause-specific critical pathology was highest for eye conditions (24.8 per 10,000 person-years). No age-specific incidence data are available from Tables X through XIII since definite data for derivation of person-years for the various age intervals are unavailable. Incidence rates and frequencies for the major body systems and all disease are available from Table X for the study group.

3. Incidence of Disease for Airmen Still Active (Table XI). The still active sub-group provided 700,752 person-years of observation Abdominal pathology represented the highest total cause-specific incidence rate for airmen still active (107.4 per 10,000 person-years). Cardiovascular disease was second highest (48.8 per 10,000 person-years) and eye conditions were highest in the critical cause-specific pathology category (23.0 per 10,000 person-years). Cause-specific

incidence was lower than total study group incidence in all instances, as was total (crude) incidence of all disease for the airmen still active sub-group (see Table XIII). When compared with the total study group, total cause-specific incidence rates were significantly different for all but the ear, nose, throat and mouth disease category which was not significant and for respiratory disease which was significant at .10.

4. Incidence of Disease Among Airmen Defined as Attrition (Table XII). 77,514 person-years were observed among airmen entering the study and subsequently defined as attrition. Miscellaneous conditions represented the highest total cause-specific incidence category among the attrition sub-group (203.8 per 10,000 person-years). Abdominal (187.8 per 10,000 person-years) and cardiovascular diseases (183.8 per 10,000 person-years) were close seconds. Cause-specific critical pathology was highest for cardiovascular diseases (90.3 per 10,000 person-years). Cause-specific incidence was higher for all major body systems and total (crude) incidence of all disease was more than double the rates for either the entire study group or the airmen still active sub-group (Table XIII). The attrition sub-group total cause-specific incidence rates were all significantly different from either the total study group or the still active sub-group.

D. *Most Recent FAA Examination and Pathology Status*

Table XIV shows that 80,366 members (26.2%) of the study group provided no follow-up information (see 1965 Subtotal). The remainder of the study group provided one or more years of observation with 148,560 (48.5%) providing observation data for the entire study period, i.e., most recent FAA examination during 1969. Data in Table XIV contain only the latest pathology status informarion differentiated by critical and non-critical disease for the study group as of the latest examination and, therefore, do not necessarily reflect an accumulation of all previous disease conditions. The latest pathology status of those involved in attrition (most recent examination prior to 1968) was worse overall than those still active (see percentages "without pathology" in Table XIV).

Critical pathology among the attrition sub-group was also higher for those providing follow-up medical data (latest examination 1966 or 1967 versus 1965). Critical rate comparisons were significant for those attrition group members providing follow-up (1966 and 1967) versus still active airmen (1968 and 1969). Prevalence of non-critical pathology decreased substantially among still actives (4.5% versus 10.3% and 12.1%). Non-critical pathology rate differences were also significant for the attrition sub-group versus still active airmen sub-group.

These findings, based on the latest pathology status of study group members, paralleled findings of the previous FAA report dealing with medical contribution to attrition.[1] The previous report contained prevalence data on a group of airmen who were involved in attrition during one year whereas, this report considers a three-year contribution to attrition and latest examination pathology data. The more complete data contained in this study have provided an important addendum. While it is still true that the prevalence of critical pathology among airmen still active is greater proportionally than that among all attrition airmen when considered as a single group, Table XIV also shows the importance of medical factors among those members of the attrition group who did provide follow-up examination data (latest examination 1966 or 1967). About two-thirds of the attrition group did not provide follow-up and the latest pathology status data suggested a lower prevalence of critical pathology than for either the attrition group members who did provide follow-up or the still active group, i.e., 2.4% of the applicants whose latest examination was during 1965 versus 3.9% for members of the attrition group who did provide follow-up (latest examination 1966 or 1967) and 3.5% for the still active group (latest examination 1968 or 1969). Non-critical pathology is, of course, still greater among the attrition group regardless of the comparison.

The conclusion to be drawn from these data is that the prevalence of critical pathology among all attrition group members is diluted by the low prevalence for those who had only the one examination during 1965. When the attrition group is sub-grouped by whether or not follow-up examination data were received, the importance of medical factors as a possible reason for attrition becomes more apparent for those 1,655 airmen providing follow-up (see 1966 and 1967 Subtotal).

E. *Distribution of Attrition and Still Active Sub-Groups by Most Recent Class of Medical Certificate*

Tables XIV and XV provide further evidence that attrition is due primarily to factors other than medical. While Table XIV strongly suggests that medical factors are an important cause of attrition for those airmen who provided follow-up examination data and could conceivably have been important for those with non-critical pathology, Table XIV also clearly indicates that about 86% of the attrition sub-group had no recorded disease and, therefore, probably no medical factors motivating their attrition. Further, one would not expect to observe the proportional relationships found in Table XV if medical factors were primary contributors to attrition; in fact, a reverse relationship would be anticipated under such a premise since Class I applicants must meet more vigorous medical standards. The disproportionate findings with respect to class of medical certificate last held for the attrition sub-group versus the still active sub-group suggest the importance of other factors as principal motivators for attrition.

IV. Summary

Cause-specific prevalence of disease among the study group was highest for abdominal conditions. Eye conditions were the most prevalent critical pathology. As expected, disease prevalence generally increased with age in total and sub-group comparisons. However, disease prevalence was highest for the attrition sub-group even though they were slightly younger.

Frequency of examination by age approaches symmetry with the higher frequencies of examination in the middle age intervals. Cause-specific incidence of disease increased with frequency of examination up to a frequency of 6–7 examinations during the 5 year interval and decreased beyond that point. Abdominal and cardiovascular diseases represented the greatest incidence for the total study group and the still active sub-group. Miscellaneous conditions, i.e., skin diseases, endocrinopathies, allergies, and general systemic conditions, were slightly more important than abdominal and cardiovascular disease among the attrition sub-group.

The attrition sub-group demonstrated the highest prevalence and incidence of disease for the study period. Findings of this study expand data available through a previous FAA effort of a similar nature to appraise the contribution of medical factors to attrition.[1] While this relationship between airmen involved in attrition and still active airmen existed with respect to disease prevalence and incidence, 86% of the attrition sub-group still had no recorded disease, thus diminshing the apparent importance of medical factors as motivators for attrition. Class of medical certificate data also suggest other causes as principal motivators for attrition.

REFERENCES

1. Booze, C. F., Jr: Attrition From Active Airman Status During 1970. FAA–AM–72–13, Office of Aviation Medicine, Federal Aviation Administration, March 1972.
2. MacMahon, Brian, et al. *Epidemiologic Methods.* Little Brown, 1970.
3. Vital Statistics of the United States. Vol. I, pp. 28–29, U.S. Department of Health, Education, and Welfare, Public Health Service, Washington, D. C., 1950.
4. Fox, John P., et al. *Epidemiology, Man and Disease.* The Macmillian Company, 1970.

TABLE I
YEAR OF MOST RECENT FAA EXAMINATION FOR ALL 1965 CERTIFIED APPLICANTS

Year	*Frequency*	*Percent*	*Years Of Observation*	*Col. 2 x Col. 4 Person-Years*	
1965	80,366	26.2	0	0	
1966	6,498	2.1	1	6,498	
1967	35,508	11.6	2	71,016	
Attrition Subtotal	122,372	39.9			77,514
1968	35,504	11.6	3	106,512	
1969	148,560	48.5	4	594,240	
Still Active Subtotal	184,064	60.1			700,752
TOTAL	306,436	100.0		778,266	

Table II
PREVALENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY AMONG 1965 APPLICANTS BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	Frequency of Occurrence	Prevalence Per 1,000
Eye													
Critical Path Freq	268	569	499	470	459	431	334	180	94	54	35	3,393	1
Non-Critical Path Freq	109	259	328	377	403	466	315	150	81	32	23	2,543	
Total Cell Frequency	377	828	827	847	862	897	649	330	175	86	58	5,936	
Prevalence Rate per 1,000	22.3	19.4	18.3	17.3	18.8	18.1	20.5	22.3	25.0	33.7	50.9		1
Ears, Nose, Throat & Mouth													
Critical Path Freq	2	3	6	14	6	10	9	10	9	4	-	73	
Non-Critical Path Freq	64	202	262	358	339	429	334	155	70	22	11	2,246	
Total Cell Frequency	66	205	268	372	345	439	343	165	79	26	11	2,319	
Prevalence Rate per 1,000	3.9	4.8	5.9	7.6	7.5	8.9	10.8	11.1	11.3	10.2	9.7		
Respiratory													
Critical Path Freq	-	1	-	9	5	7	14	8	2	-	-	46	
Non-Critical Path Freq	26	125	179	190	186	216	135	61	26	11	10	1,165	
Total Cell Frequency	26	126	179	199	191	223	149	69	28	11	10	1,211	
Prevalence Rate per 1,000	1.5	3.0	4.0	4.1	4.2	4.5	4.7	4.7	4.0	4.3	8.8		
Cardiovascular													
Critical Path Freq	2	18	21	40	87	156	148	117	80	26	12	707	
Non-Critical Path Freq	223	627	521	506	509	629	430	207	130	60	34	3,876	1
Total Cell Frequency	225	645	542	546	596	785	578	324	210	86	46	4,583	
Prevalence Rate per 1,000	13.3	15.1	12.0	11.2	13.0	15.8	18.2	21.9	30.0	33.7	40.4		1
Abdominal													
Critical Path Freq	2	21	33	69	64	128	96	42	37	20	9	521	
Non-Critical Path Freq	369	1,222	1,737	2,365	2,684	3,402	2,529	1,419	776	292	150	16,945	5
Total Cell Frequency	371	1,243	1,770	2,434	2,748	3,530	2,625	1,461	813	312	159	17,466	
Prevalence Rate per 1,000	21.9	29.1	39.1	49.7	60.0	71.2	82.8	98.6	116.0	122.2	139.6		5
Neuropsychiatric													
Critical Path Freq	11	17	25	31	39	43	36	15	7	2	-	226	
Non-Critical Path Freq	145	344	344	372	461	559	325	134	62	19	10	2,775	
Total Cell Frequency	156	361	369	403	500	602	361	149	69	21	10	3,001	
Prevalence Rate per 1,000	9.2	8.5	8.1	8.2	10.9	12.1	11.4	10.1	9.8	8.2	8.8		
Bones and Joints													
Critical Path Freq	17	51	93	120	169	235	158	100	65	22	4	1,034	
Non-Critical Path Freq	107	363	353	462	510	681	521	218	125	31	20	3,391	1
Total Cell Frequency	124	414	446	582	679	916	679	318	190	53	24	4,425	
Prevalence Rate per 1,000	7.3	9.7	9.8	11.9	14.8	18.5	21.4	21.5	27.1	20.8	21.1		1
Muscles													
Critical Path Freq	17	29	48	48	74	68	46	28	17	2	2	379	
Non-Critical Path Freq	7	19	21	19	22	18	21	13	3	3	1	147	
Total Cell Frequency	24	48	69	67	96	86	67	41	20	5	3	526	
Prevalence Rate per 1,000	1.4	1.1	1.5	1.4	2.1	1.7	2.1	2.8	2.9	2.0	2.6		
Miscellaneous Conditions													
Critical Path Freq	3	23	26	48	72	111	103	64	22	14	4	490	
Non-Critical Path Freq	375	725	550	587	614	599	454	182	84	21	9	4,200	1
Total Cell Frequency	378	748	576	635	686	710	557	246	106	35	13	4,690	
Prevalence Rate per 1,000	22.3	17.5	12.7	13.0	15.0	14.3	17.6	16.6	15.1	13.7	11.4		1
TOTAL													
Critical Path Freq	316	722	737	833	949	1,164	916	549	323	140	64	6,713	2
Non-Critical Path Freq	1,315	3,601	3,935	4,746	5,167	6,281	4,437	2,236	1,167	435	213	33,533	10
Total Freq for Age Group	1,631	4,323	4,672	5,579	6,116	7,445	5,353	2,785	1,490	575	277	40,246	
Prev. Rate for Age Group per 1,000	96.4	101.4	103.1	113.9	133.5	150.2	168.9	188.1	212.6	225.1	243.2		13

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Prevalence is defined as that pathology present on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

Row totals represent the prevalence of pathology, by body system, among all 1965 applicants. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple prevalence within a system or category is counted on according to category. The row total for a body system does represent airmen.

Column totals represent prevalence of any pathology regardless of system recorded on the first examination during 1965 by age interval and category. Indiv column values are not additive downward; however, column totals do reflect prevalence of critical, non-critical, and total for the age interval and are add for prevalence of critical, non-critical, and total for the population. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table III
PREVALENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
AMONG AIRMEN STILL ACTIVE BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	≥65	Frequency of Occurrence	Prevalence Rate Per 1,000 Airmen
Eye													
Critical Path Freq	88	228	247	273	274	244	211	96	57	33	21	1,772	9.7
Non-Critical Path Freq	37	118	165	215	218	285	206	95	52	20	13	1,424	7.8
Total Cell Frequency	125	346	412	488	492	529	417	191	109	53	34	3,196	
Prevalence Rate per 1,000	18.7	16.9	15.3	15.8	17.4	16.2	19.9	19.8	25.6	36.9	59.2		17.5
Ears, Nose, Throat & Mouth													
Critical Path Freq	-	1	3	7	2	4	6	9	4	2	-	38	0.2
Non-Critical Path Freq	19	74	135	218	201	273	223	85	41	10	7	1,286	7.0
Total Cell Frequency	19	75	138	225	203	277	229	94	45	12	7	1,324	
Prevalence Rate per 1,000	2.8	3.7	5.1	7.3	7.2	8.5	10.9	9.7	10.6	8.4	12.2		7.2
Respiratory													
Critical Path Freq	-	-	-	5	3	3	4	4	1	-	-	20	0.1
Non-Critical Path Freq	11	48	86	113	99	123	85	32	18	4	2	621	3.4
Total Cell Frequency	11	48	86	118	102	126	89	36	19	4	2	641	
Prevalence Rate per 1,000	1.6	2.3	3.2	3.8	3.6	3.9	4.2	3.7	4.5	2.8	3.5		3.5
Cardiovascular													
Critical Path Freq	1	6	9	20	41	77	81	65	38	11	5	354	2.0
Non-Critical Path Freq	74	261	268	291	299	369	251	130	68	26	12	2,049	11.2
Total Cell Frequency	75	267	277	311	340	446	332	195	106	37	17	2,403	
Prevalence Rate per 1,000	11.2	13.0	10.3	10.1	12.0	13.7	15.8	20.2	24.9	25.8	29.6		13.2
Abdominal													
Critical Path Freq	1	9	15	47	33	86	73	25	19	12	5	325	1.8
Non-Critical Path Freq	146	563	941	1,382	1,542	2,086	1,550	876	449	155	70	9,760	53.4
Total Cell Frequency	147	572	956	1,429	1,575	2,172	1,623	901	468	167	75	10,085	
Prevalence Rate per 1,000	21.9	27.9	35.6	46.2	55.8	66.6	77.5	93.3	109.9	116.3	130.7		55.2
Neuropsychiatric													
Critical Path Freq	4	8	14	18	23	28	20	7	5	2	-	129	0.7
Non-Critical Path Freq	57	121	175	199	253	310	186	84	28	9	5	1,427	7.8
Total Cell Frequency	61	129	189	217	276	338	206	91	33	11	5	1,556	
Prevalence Rate per 1,000	9.1	6.3	7.0	7.0	9.8	10.4	9.8	9.4	7.7	7.7	8.7		8.5
Bones and Joints													
Critical Path Freq	4	24	42	71	88	149	101	61	41	13	2	596	3.2
Non-Critical Path Freq	48	163	194	243	279	418	304	131	75	16	4	1,875	10.3
Total Cell Frequency	52	187	236	314	367	567	405	192	116	29	6	2,471	
Prevalence Rate per 1,000	7.8	9.1	8.8	10.2	13.0	17.4	19.3	19.9	27.2	20.2	10.4		13.5
Muscles													
Critical Path Freq	8	13	22	26	37	41	27	20	10	1	-	205	1.1
Non-Critical Path Freq	2	12	13	5	10	9	15	6	2	1	-	75	0.4
Total Cell Frequency	10	25	35	31	47	50	42	26	12	2	-	280	
Prevalence Rate per 1,000	1.5	1.2	1.3	1.0	1.7	1.5	2.0	2.7	2.8	1.4	-		1.5
Miscellaneous Conditions													
Critical Path Freq	-	16	13	28	33	55	51	36	10	6	1	249	1.3
Non-Critical Path Freq	118	262	250	298	297	299	232	87	28	5	2	1,878	10.3
Total Cell Frequency	118	278	263	326	330	354	283	123	38	11	3	2,127	
Prevalence Rate per 1,000	17.6	13.6	9.8	10.5	11.7	10.9	13.5	12.7	8.9	7.7	5.2		11.6
TOTAL													
Critical Path Freq	104	300	356	487	522	675	559	316	178	79	34	3,610	19.8
Non-Critical Path Freq	481	1,520	2,049	2,692	2,909	3,780	2,700	1,361	670	217	91	18,470	101.1
Total Freq for Age Group	585	1,820	2,405	3,179	3,431	4,455	3,259	1,677	848	296	125	22,080	
Prev. Rate for Age Group per 1,000	87.3	88.9	89.5	102.8	121.5	136.6	155.6	173.6	199.2	206.1	217.8		120.9

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Prevalence is defined as that pathology present on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

An airman is considered currently active if his most recent examination was within the preceding 24 calendar months as of 1 January 1970 and was certified as meeting medical standards.

Row totals represent the prevalence of pathology, by body system, among airmen still active. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple prevalence within a system or category is counted once according to category. The row total for a body system does represent airmen.

Column totals represent prevalence of any pathology regardless of system recorded on the first examination during 1965 by age interval and category. Individual column values are not additive downward; however, column totals do reflect prevalence of critical, non-critical, and total for the age interval and are additive for prevalence of critical, non-critical, and total for the population. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certifification Branch, Medical Statistical Section.

Table IV

PREVALENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
AMONG ATTRITION GROUP BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	Frequency of Occurrence	Prevalence Rate Per 1,000 Airmen
Eye													
Critical Path Freq	180	341	252	197	185	187	123	84	37	21	14	1,621	13.1
Non-Critical Path Freq	72	141	163	162	185	181	109	55	29	12	10	1,119	9.0
Total Cell Frequency	252	482	415	359	370	368	232	139	66	33	24	2,740	
Prevalence Rate per 1,000	24.7	21.7	22.5	19.9	21.0	21.7	21.6	27.0	24.0	29.5	42.5		22.1
Ears, Nose, Throat & Mouth													
Critical Path Freq	2	2	3	7	4	6	3	1	5	2	-	35	0.3
Non-Critical Path Freq	45	128	127	140	138	156	111	70	29	12	4	960	7.7
Total Cell Frequency	47	130	130	147	142	162	114	71	34	14	4	995	
Prevalence Rate per 1,000	4.6	5.9	7.0	8.1	8.1	9.6	10.6	13.8	12.4	12.5	7.1		8.0
Respiratory													
Critical Path Freq	-	1	-	4	2	4	10	4	1	-	-	26	0.2
Non-Critical Path Freq	15	77	93	77	87	93	50	29	8	7	8	544	4.4
Total Cell Frequency	15	78	93	81	89	97	60	33	9	7	8	570	
Prevalence Rate per 1,000	1.5	3.5	5.0	4.5	5.1	5.7	5.6	6.4	3.3	6.3	14.2		4.6
Cardiovascular													
Critical Path Freq	1	12	12	20	46	79	67	52	42	15	7	353	2.8
Non-Critical Path Freq	149	366	253	215	210	260	179	77	62	34	22	1,827	14.8
Total Cell Frequency	150	378	265	235	256	339	246	129	104	49	29	2,180	
Prevalence Rate per 1,000	14.7	17.0	14.4	13.0	14.6	20.0	22.9	25.0	37.8	43.8	51.3		17.6
Abdominal													
Critical Path Freq	1	12	18	22	31	42	23	17	18	8	4	196	1.6
Non-Critical Path Freq	223	659	796	983	1,142	1,316	979	543	327	137	80	7,185	58.1
Total Cell Frequency	224	671	814	1,005	1,173	1,358	1,002	560	345	145	84	7,381	
Prevalence Rate per 1,000	21.9	30.2	44.1	55.7	66.7	80.1	93.3	108.7	125.5	129.7	148.7		59.7
Neuropsychiatric													
Critical Path Freq	7	9	11	13	16	15	16	8	2	-	-	97	0.8
Non-Critical Path Freq	88	223	169	173	208	249	139	50	34	10	5	1,348	10.9
Total Cell Frequency	95	232	180	186	224	264	155	58	36	10	5	1,445	
Prevalence Rate per 1,000	9.3	10.5	9.8	10.3	12.7	15.6	14.4	11.3	13.1	8.9	8.8		11.7
Bones and Joints													
Critical Path Freq	13	27	51	49	81	86	57	39	24	9	2	438	3.5
Non-Critical Path Freq	59	200	159	219	231	263	217	87	50	15	16	1,516	12.3
Total Cell Frequency	72	227	210	268	312	349	274	126	74	24	18	1,954	
Prevalence Rate per 1,000	7.0	10.2	11.4	15.0	17.7	20.6	25.5	24.5	26.9	21.5	31.9		15.8
Muscles													
Critical Path Freq	9	16	26	22	37	27	19	8	7	1	2	174	1.4
Non-Critical Path Freq	5	7	8	14	12	9	6	7	1	2	1	72	0.6
Total Cell Frequency	14	23	34	36	49	36	25	15	8	3	3	246	
Prevalence Rate per 1,000	1.4	1.0	1.8	2.0	2.8	2.1	2.3	2.9	2.9	2.7	5.3		2.0
Miscellaneous Conditions													
Critical Path Freq	3	7	13	20	39	56	52	28	12	8	3	241	1.9
Non-Critical Path Freq	257	463	300	289	317	300	222	95	56	16	7	2,322	18.8
Total Cell Frequency	260	470	313	309	356	356	274	123	68	24	10	2,563	
Prevalence Rate per 1,000	25.4	21.2	17.0	17.1	20.2	21.0	25.5	23.9	24.7	21.5	17.7		20.7
TOTAL													
Critical Path Freq	212	422	381	346	427	489	357	233	145	61	30	3,103	25.1
Non-Critical Path Freq	834	2,081	1,886	2,054	2,258	2,501	1,737	875	497	218	122	15,063	121.7
Total Freq for Age Group	1,046	2,503	2,267	2,400	2,685	2,990	2,094	1,108	642	279	152	18,166	
Prev. Rate for Age Group per 1,000	102.3	112.8	123.0	133.0	152.6	176.3	195.0	215.1	233.4	249.5	269.0		146.8

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Prevalence is defined as that pathology present on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

Attrition includes those originally issued in 1965 whose most recent examination was over 24 calendar months ago as of 1 January 1970; also, includes those denied subsequent to their examination in 1965.

Row totals represent the prevalence of pathology, by body system, among the attrition group. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple prevalence within a system or category is counted once according to category. The row total for a body system does represent airmen.

Column totals represent prevalence of any pathology regardless of system recorded on the first examination during 1965 by age interval and category. Individual column values are not additive downward; however, column totals do reflect prevalence of critical, non-critical, and total for the age interval and are additive for prevalence of critical, non-critical, and total for the population. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table V

PREVALENCE OF PATHOLOGY BY AGE AND BODY SYSTEM
1965 APPLICANTS VERSUS ATTRITION VERSUS AIRMEN STILL ACTIVE
(000)

Body System	Age At Entry											Total Prevalence Rate Per 1,000 Airmen
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	
Eye												
1965 Applicants	22.3	19.4	18.3	17.3	18.8	18.1	20.5	22.3	25.0	33.7	50.9	19.4
Attrition Group	24.7	21.7	22.5	19.9	21.0	21.7	21.6	27.0	24.0	29.5	42.5	22.1
Airmen Still Active	18.7	16.9	15.3	15.8	17.4	16.2	19.9	19.8	25.6	36.9	59.2	17.5
Ears, Nose, Throat & Mouth												
1965 Applicants	3.9	4.8	5.9	7.6	7.5	8.9	10.8	11.1	11.3	10.2	9.7	7.5
Attrition Group	4.6	5.9	7.0	8.1	8.1	9.6	10.6	13.8	12.4	12.5	7.1	8.0
Airmen Still Active	2.8	3.7	5.1	7.3	7.2	8.5	10.9	9.7	10.6	8.4	12.2	7.2
Respiratory												
1965 Applicants	1.5	3.0	4.0	4.1	4.2	4.5	4.7	4.7	4.0	4.3	8.8	4.0
Attrition Group	1.5	3.5	5.0	4.5	5.1	5.7	5.6	6.4	3.3	6.3	14.2	4.6
Airmen Still Active	1.6	2.3	3.2	3.8	3.6	3.9	4.2	3.7	4.5	2.8	3.5	3.5
Cardiovascular												
1965 Applicants	13.3	15.1	12.0	11.2	13.0	15.8	18.2	21.9	30.0	33.7	40.4	14.9
Attrition Group	14.7	17.0	14.4	13.0	14.6	20.0	22.9	25.0	37.8	43.8	51.3	17.6
Airmen Still Active	11.2	13.0	10.3	10.1	12.0	13.7	15.8	20.2	24.9	25.8	29.6	13.2
Abdominal												
1965 Applicants	21.9	29.1	39.1	49.7	60.0	71.2	82.8	98.6	116.0	122.2	139.6	57.0
Attrition Group	21.9	30.2	44.1	55.7	66.7	80.1	93.3	108.7	125.5	129.7	148.7	59.7
Airmen Still Active	21.9	27.9	35.6	46.2	55.8	66.6	77.5	93.3	109.9	116.3	130.7	55.2
Neuropsychiatric												
1965 Applicants	9.2	8.5	8.1	8.2	10.9	12.1	11.4	10.1	9.8	8.2	8.8	9.8
Attrition Group	9.3	10.5	9.8	10.3	12.7	15.6	14.4	11.3	13.1	8.9	8.8	11.7
Airmen Still Active	9.1	6.3	7.0	7.0	9.8	10.4	9.8	9.4	7.7	7.7	8.7	8.5
Bones and Joints												
1965 Applicants	7.3	9.7	9.8	11.9	14.8	18.5	21.4	21.5	27.1	20.8	21.1	14.4
Attrition Group	7.0	10.2	11.4	15.0	17.7	20.6	25.5	24.5	26.9	21.5	31.9	15.8
Airmen Still Active	7.8	9.1	8.8	10.2	13.0	17.4	19.3	19.9	27.2	20.2	10.4	13.5
Muscles												
1965 Applicants	1.4	1.1	1.5	1.4	2.1	1.7	2.1	2.8	2.9	2.0	2.6	1.7
Attrition Group	1.4	1.0	1.8	2.0	2.8	2.1	2.3	2.9	2.9	2.7	5.3	2.0
Airmen Still Active	1.5	1.2	1.3	1.0	1.7	1.5	2.0	2.7	2.8	1.4	0.0	1.5
Miscellaneous Conditions												
1965 Applicants	22.3	17.5	12.7	13.0	15.0	14.3	17.6	16.6	15.1	13.7	11.4	15.3
Attrition Group	25.4	21.2	17.0	17.1	20.2	21.0	25.5	23.9	24.7	21.5	17.7	20.7
Airmen Still Active	17.6	13.6	9.8	10.5	11.7	10.9	13.5	12.7	8.9	7.7	5.2	11.6
TOTAL FOR AGE GROUP												
1965 Applicants	96.4	101.4	103.1	113.9	133.5	150.2	168.9	188.1	212.6	225.1	243.2	131.3
Attrition Group	102.3	112.8	123.0	133.0	152.6	176.3	195.0	215.1	233.4	249.5	269.0	146.8
Airmen Still Active	87.3	88.9	89.5	102.8	121.5	136.6	155.6	173.6	199.2	206.1	217.8	120.9

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table VI

AGE DISTRIBUTION BY FREQUENCY OF FAA EXAMINATION DURING STUDY INTERVAL - ALL 1965 APPLICANTS

Age At Entry	Frequency of Examination*										Average Frequency Of Examination	Total
	1	2	3	4	5	6	7	8	9	10+		
< 20	7,643	3,983	2,852	1,346	796	243	51	7	-	-	2.1	16,921
20-24	16,505	8,579	7,007	4,171	4,099	1,536	421	160	116	71	2.5	42,665
25-29	12,740	8,162	7,778	4,629	7,053	2,738	896	610	349	357	3.1	45,312
30-34	11,451	9,504	10,498	4,809	7,266	2,203	856	913	754	710	3.2	48,964
35-39	10,694	10,073	11,994	3,565	5,069	1,113	574	647	918	1,174	3.1	45,821
40-44	9,662	9,494	12,696	4,180	6,866	1,179	494	673	1,264	3,048	3.5	49,556
45-49	6,028	5,917	8,528	2,648	4,473	593	243	269	695	2,292	3.6	31,686
50-54	2,822	2,849	4,680	1,158	1,925	149	82	74	230	842	3.3	14,811
55-59	1,405	1,421	2,361	506	877	85	76	81	92	103	3.0	7,007
60-64	592	554	882	186	311	11	5	3	6	4	2.7	2,554
> 65	314	251	378	79	109	5	1	1	1	-	2.5	1,139
TOTAL	79,856	60,787	69,654	27,277	38,844	9,855	3,699	3,438	4,425	8,601	3.1	306,436
Percent	26.1	19.8	22.7	8.9	12.7	3.2	1.2	1.1	1.5	2.8		100.0
Mean Age	32.5	34.9	37.2	34.3	35.8	32.0	33.6	35.8	39.2	42.2		35.0

*Number of examinations between 1 January 1965 and 1 January 1970.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table VII

AGE DISTRIBUTION BY FREQUENCY OF FAA EXAMINATION DURING STUDY INTERVAL - AIRMEN STILL ACTIVE-1 January 1970

Age At Entry	Frequency of Examination*									Average Frequency Of Examination	Total
	1	2	3	4	5	6	7	8	9	10+		
<20		1,687	2,608	1,319	786	241	51	7	-	-	3.3	6,699
20-24		3,720	6,296	4,087	4,075	1,530	421	159	116	71	3.8	20,475
25-29		3,230	7,129	4,539	7,033	2,733	895	610	349	356	4.3	26,874
30-34		3,852	9,716	4,701	7,238	2,192	851	913	754	710	4.3	30,927
35-39		3,940	11,390	3,476	5,024	1,103	570	647	914	1,174	4.1	28,238
40-44		3,439	11,746	4,031	6,797	1,153	476	663	1,258	3,042	4.6	32,605
45-49		2,067	7,895	2,545	4,410	570	232	257	684	2,286	4.6	20,946
50-54		926	4,416	1,102	1,891	126	76	67	221	835	4.2	9,660
55-59		391	2,176	453	834	58	75	79	90	101	3.9	4,257
60-64		113	811	178	306	10	5	3	6	4	3.6	1,436
>65		37	344	77	108	5	1	1	1	-	3.5	574
TOTAL		23,402	64,527	26,508	38,502	9,721	3,653	3,406	4,393	8,579	4.2	182,691
Percent		12.8	35.3	14.5	21.1	5.3	2.0	1.9	2.4	4.7		100.0
Mean Age		33.9	37.3	34.2	35.8	31.8	33.5	35.7	39.1	42.2		36.0

*Number of examinations between 1 January 1965 and 1 January 1970.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table VIII

AGE DISTRIBUTION BY FREQUENCY OF FAA EXAMINATION DURING STUDY INTERVAL - ATTRITION GROUP

Age At Entry	Frequency of Examination*										Average Frequency Of Examination	Total
	1	2	3	4	5	6	7	8	9	10+		
<20	7,643	2,296	244	27	10	2	-	-	-	-	1.3	10,222
20-24	16,505	4,859	711	84	24	6	-	1	-	-	1.3	22,190
25-29	12,740	4,932	649	90	20	5	1	-	-	1	1.4	18,438
30-34	11,451	5,652	782	108	28	11	5	-	-	-	1.4	18,037
35-39	10,694	6,133	604	89	45	10	4	-	4	-	1.4	17,583
40-44	9,662	6,055	950	149	69	26	18	10	6	6	1.5	16,951
45-49	6,028	3,850	633	103	63	23	11	12	11	6	1.6	10,740
50-54	2,822	1,923	264	56	34	23	6	7	9	7	1.6	5,151
55-59	1,405	1,030	185	53	43	27	1	2	2	2	1.7	2,750
60-64	592	441	71	8	5	1	-	-	-	-	1.6	1,118
>65	314	214	34	2	1	-	-	-	-	-	1.5	565
TOTAL	79,856	37,385	5,127	769	342	134	46	32	32	22	1.4	123,745
Percent	64.6	30.2	4.2	0.6	0.3	0.1	0.0+	0.0+	0.0+	0.0+		100.0
Mean Age	32.5	35.5	36.3	38.0	41.8	44.8	43.0	46.4	46.8	47.2		33.7

*Number of examinations for those originally issued in 1965 whose most recent examination was over 24 calendar months as of 1 January 1970, including those denied subsequent to their examination in 1965.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table IX

INCIDENCE OF PATHOLOGY BY FREQUENCY OF EXAMINATION AND MAJOR BODY SYSTEM
(000)

Frequency of Examination	Eye	Ears, Nose, Throat & Mouth	Respiratory	Cardiovascular	Abdominal	Neuro-Psychiatric	Bones and Joints	Muscles	Other Miscellaneous Conditions	Total
2	11.2	4.1	2.6	14.5	23.4	8.0	5.4	0.9	18.0	81.1
3	19.1	8.3	3.7	21.6	41.3	10.0	9.6	1.2	18.4	119.4
4	17.5	11.1	5.6	28.0	45.6	13.4	10.2	1.3	22.0	137.3
5	16.6	12.8	5.7	23.6	46.7	11.5	10.9	1.3	15.3	127.8
6	17.8	15.9	7.6	32.3	52.4	16.5	13.4	1.4	18.5	153.2
7	19.2	12.7	5.4	28.9	46.2	12.2	11.6	1.1	19.5	137.3
8	11.9	11.1	5.8	20.7	52.9	11.3	8.7	1.2	16.0	121.6
9	13.6	14.2	5.2	25.5	55.4	13.6	12.9	2.0	14.5	139.4
10 +	12.3	14.8	4.9	19.2	59.5	12.2	11.6	0.9	13.6	135.4
Range	11.2-19.2	4.1-15.9	2.6-7.6	14.5-32.3	23.4-59.5	8.0-16.5	5.4-13.4	0.9-2.0	13.6-22.0	81.1-153.2
Relative Increase or (Decrease) with Increased Freq. of Exam.	71.4%	287.8%	192.3%	122.8%	154.3%	106.2%	148.1%	122.2%	(38.2%)	88.9%
Absolute Increase or (Decrease) with Increased Freq. of Exam.	7.0	11.8	5.0	17.8	36.1	8.5	8.0	1.1	(8.4)	72.1

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table X

INCIDENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
AMONG 1965 APPLICANTS BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	Frequency of Occurrence	Incidence Rate Per 10,000 Person Yrs
Eye													
Critical Path Freq	160	285	256	248	241	264	213	128	75	31	28	1,929	24.8
Non-Critical Path Freq	65	157	218	247	228	327	209	114	58	19	13	1,655	21.3
Total Cell Frequency	225	442	474	495	469	591	422	242	133	50	41	3,584	46.1
Ears, Nose, Throat & Mouth													
Critical Path Freq	1	1	2	5	6	8	15	9	7	2		56	0.7
Non-Critical Path Freq	36	141	255	300	296	417	310	148	61	25	14	2,003	25.7
Total Cell Frequency	37	142	257	305	302	425	325	157	68	27	14	2,059	26.4
Respiratory													
Critical Path Freq	-	-	1	3	5	12	16	6	4	3	1	51	0.6
Non-Critical Path Freq	23	81	120	153	118	165	144	64	27	16	7	918	11.8
Total Cell Frequency	23	81	121	156	123	177	160	70	31	19	8	969	12.4
Cardiovascular													
Critical Path Freq	3	12	37	86	143	373	357	212	118	38	17	1,396	17.9
Non-Critical Path Freq	147	362	345	436	456	642	508	287	144	71	49	3,447	44.3
Total Cell Frequency	150	374	382	522	599	1,015	865	499	262	109	66	4,843	62.2
Abdominal													
Critical Path Freq	1	17	28	45	55	79	75	38	22	7	5	372	4.8
Non-Critical Path Freq	139	555	831	1,197	1,294	1,863	1,424	716	373	161	59	8,612	110.6
Total Cell Frequency	140	572	859	1,242	1,349	1,942	1,499	754	395	168	64	8,984	115.4
Neuropsychiatric													
Critical Path Freq	10	27	31	38	34	54	41	21	7	5	1	269	3.5
Non-Critical Path Freq	82	226	255	347	368	412	275	119	39	12	5	2,140	27.5
Total Cell Frequency	92	253	286	385	402	466	316	140	46	17	6	2,409	31.0
Bones and Joints													
Critical Path Freq	9	29	44	58	76	121	76	42	29	12	1	497	6.4
Non-Critical Path Freq	41	99	166	216	219	333	272	129	66	14	7	1,562	20.1
Total Cell Frequency	50	128	210	274	295	454	348	171	95	26	8	2,059	26.5
Muscles													
Critical Path Freq	4	13	11	20	23	38	25	10	3	-	-	147	1.9
Non-Critical Path Freq	1	6	12	15	17	25	18	10	4	8	2	118	1.5
Total Cell Frequency	5	19	23	35	40	63	43	20	7	8	2	265	3.4
Miscellaneous Conditions													
Critical Path Freq	6	22	44	64	77	157	133	74	23	10	9	619	8.0
Non-Critical Path Freq	154	308	404	484	543	625	492	247	119	40	25	3,441	44.2
Total Cell Frequency	160	330	448	548	620	782	625	321	142	50	34	4,060	52.2
TOTAL													
Critical Path Freq	194	401	451	555	649	1,065	915	517	280	101	60	5,188	66.7
Non-Critical Path Freq	628	1,779	2,364	3,056	3,177	4,198	3,081	1,496	764	300	140	20,983	269.6
Total Frequency for Age Group	822	2,180	2,815	3,611	3,826	5,263	3,996	2,013	1,044	401	200	26,171	336.3

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Incidence of disease is defined as the occurrence of pathology other than that recorded on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

Row totals represent the incidence of pathology by body system among all 1965 applicants. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple incidence within a system is counted once according to category. The row total for a system does represent airmen.

Column totals represent the incidence of pathology, regardless of system, by category, recorded since the first examination during 1965, by age interval, among all 1965 applicants. Individual column values are not additive downward; however, column totals are additive across for incidence by category of pathology during the interval. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table XI

INCIDENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
AMONG AIRMEN STILL ACTIVE BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	Frequency of Occurrence	Incidence Rate Per 10,000 Person Yrs.
Eye													
Critical Path Freq	129	243	203	219	202	222	183	109	58	25	22	1,615	23.0
Non-Critical Path Freq	48	132	190	219	198	276	174	94	48	11	8	1,398	20.0
Total Cell Frequency	177	375	393	438	400	498	357	203	106	36	30	3,013	43.0
Ears, Nose, Throat & Mouth													
Critical Path Freq	1	-	1	4	6	6	13	7	7	1	-	46	0.7
Non-Critical Path Freq	31	111	219	263	256	366	273	127	46	23	11	1,726	24.6
Total Cell Frequency	32	111	220	267	262	372	286	134	53	24	11	1,772	25.3
Respiratory													
Critical Path Freq	-	-	1	3	4	9	14	4	1	1	1	38	0.5
Non-Critical Path Freq	18	67	102	127	103	143	109	52	17	10	6	754	10.8
Total Cell Frequency	18	67	103	130	107	152	123	56	18	11	7	792	11.3
Cardiovascular													
Critical Path Freq	2	8	26	42	86	186	178	101	44	17	6	696	9.9
Non-Critical Path Freq	112	297	299	362	373	515	394	206	92	42	30	2,722	38.9
Total Cell Frequency	114	305	325	404	459	701	572	307	136	59	36	3,418	48.8
Abdominal													
Critical Path Freq	1	13	22	40	48	62	62	28	17	5	2	300	4.3
Non-Critical Path Freq	107	455	709	1,033	1,075	1,581	1,204	605	293	120	46	7,228	103.1
Total Cell Frequency	108	468	731	1,073	1,123	1,643	1,266	633	310	125	48	7,528	107.4
Neuropaychiatric													
Critical Path Freq	3	10	10	11	15	25	10	4	1	1	-	90	1.3
Non-Critical Path Freq	53	154	200	272	271	323	210	78	23	8	2	1,594	22.7
Total Cell Frequency	56	164	210	283	286	348	220	82	24	9	2	1,684	24.0
Bones and Joints													
Critical Path Freq	8	24	37	46	61	98	63	35	27	7	-	406	5.8
Non-Critical Path Freq	25	81	130	192	185	280	228	102	52	10	6	1,291	18.4
Total Cell Frequency	33	105	167	238	246	378	291	137	79	17	6	1,697	24.2
Muscles													
Critical Path Freq	3	11	9	19	17	30	19	10	1	-	-	119	1.7
Non-Critical Path Freq	1	4	11	12	13	19	14	8	3	5	1	91	1.3
Total Cell Frequency	4	15	20	31	30	49	33	18	4	5	1	210	3.0
Miscellaneous Conditions													
Critical Path Freq	4	17	33	50	57	120	91	58	14	7	4	455	6.5
Non-Critical Path Freq	94	184	257	312	317	354	299	135	46	19	8	2,025	28.9
Total Cell Frequency	98	201	290	362	374	474	390	193	60	26	12	2,480	35.4
TOTAL													
Critical Path Freq	151	321	339	425	486	734	612	343	166	61	33	3,671	52.4
Non-Critical Path Freq	442	1,367	1,932	2,532	2,514	3,435	2,515	1,187	550	212	97	16,783	239.5
Total Frequency for Age Group	593	1,688	2,271	2,957	3,000	4,169	3,127	1,530	716	273	130	20,454	291.9

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Incidence of disease is defined as the occurrence of pathology other than that recorded on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

An airman is considered currently active if his most recent examination was within the preceding 24 calendar months as of 1 January 1970 and was certified as meeting medical standards.

Row totals represent the incidence of pathology by body system among airmen still active as of 1 January 1970. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple incidence within a system is counted once according to category. The row total for a system does represent airmen.

Column totals represent the incidence of pathology, regardless of system, by category, recorded since the first examination during 1965, by age interval, among airmen still active as of 1 January 1970. Individual column values are not additive downward; however, column totals are additive across for incidence by category of pathology during the interval. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table XII

INCIDENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
AMONG ATTRITION GROUP BY AGE AND BODY SYSTEM

Body System	Age At Entry											Total	
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>65	Frequency of Occurrence	Incidence Rate Per 10,000 Person Yrs
Eye													
Critical Path Freq	31	42	53	29	39	42	30	19	17	6	6	314	40.5
Non-Critical Path Freq	17	25	28	28	30	51	35	20	10	8	5	257	33.2
Total Cell Frequency	48	67	81	57	69	93	65	39	27	14	11	571	73.7
Ears, Nose, Throat & Mouth													
Critical Path Freq	-	1	1	1	-	2	2	2	-	1	-	10	1.3
Non-Critical Path Freq	5	30	36	37	40	51	37	21	15	2	3	277	35.7
Total Cell Frequency	5	31	37	38	40	53	39	23	15	3	3	287	37.0
Respiratory													
Critical Path Freq	-	-	-	-	1	3	2	2	3	2	-	13	1.7
Non-Critical Path Freq	5	14	18	26	15	22	35	12	10	6	1	164	21.1
Total Cell Frequency	5	14	18	26	16	25	37	14	13	8	1	177	22.8
Cardiovascular													
Critical Path Freq	1	4	11	44	57	187	179	111	74	21	11	700	90.3
Non-Critical Path Freq	35	65	46	74	83	127	114	81	52	29	19	725	93.5
Total Cell Frequency	36	69	57	118	140	314	293	192	126	50	30	1,425	183.8
Abdominal													
Critical Path Freq	-	4	6	5	7	17	13	10	5	2	3	72	9.3
Non-Critical Path Freq	32	100	122	164	219	282	220	111	80	41	13	1,384	178.5
Total Cell Frequency	32	104	128	169	226	299	233	121	85	43	16	1,456	187.8
Neuropsychiatric													
Critical Path Freq	7	17	21	27	19	29	31	17	6	4	1	179	23.1
Non-Critical Path Freq	29	72	55	75	97	89	65	41	16	4	3	546	70.4
Total Cell Frequency	36	89	76	102	116	118	96	58	22	8	4	725	93.5
Bones and Joints													
Critical Path Freq	1	5	7	12	15	23	13	7	2	5	1	91	11.7
Non-Critical Path Freq	16	18	36	24	34	53	44	27	14	4	1	271	35.0
Total Cell Frequency	17	23	43	36	49	76	57	34	16	9	2	362	46.7
Muscles													
Critical Path Freq	1	2	2	1	6	8	6	-	2	-	-	28	3.6
Non-Critical Path Freq	-	2	1	3	4	6	4	2	1	3	1	27	3.5
Total Cell Frequency	1	4	3	4	10	14	10	2	3	3	1	55	7.1
Miscellaneous Conditions													
Critical Path Freq	2	5	11	14	20	37	42	16	9	3	5	164	21.1
Non-Critical Path Freq	60	124	147	172	226	271	193	112	73	21	17	1,416	182.7
Total Cell Frequency	62	129	158	186	246	308	235	128	82	24	22	1,580	203.8
TOTAL													
Critical Path Freq	43	80	112	130	163	331	303	174	114	40	27	1,517	195.7
Non-Critical Path Freq	186	412	432	524	663	763	566	309	214	88	43	4,200	541.8
Total Frequency for Age Group	229	492	544	654	826	1,094	869	483	328	128	70	5,717	737.5

NOTES:

Age was computed as of the date of first examination during 1965 to last birthday and represents age at entry.

Incidence of disease is defined as the occurrence of pathology other than that recorded on the first examination during 1965. Critical and non-critical codes are identified in the Appendix.

Attrition includes those originally issued in 1965 whose most recent examination was over 24 calendar months ago as of 1 January 1970; also, includes those denied subsequent to their examination in 1965.

Row totals represent the incidence of pathology by body system among the attrition group. Only categories within a system are mutually exclusive, i.e., critical, non-critical, thus row totals for the different systems are not additive downward. Multiple incidence within a system is counted once according to category. The row total for a system does represent airmen.

Column totals represent the incidence of pathology, regardless of system, by category, recorded since the first examination during 1965, by age interval, among the attrition group. Individual column values are not additive downward; however, column totals are additive across for incidence by category of pathology during the interval. Column totals do represent airmen.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table XIII

INCIDENCE OF CRITICAL AND NON-CRITICAL PATHOLOGY
1965 APPLICANTS VERSUS ATTRITION VERSUS AIRMEN STILL ACTIVE

Body System	Incidence Rate per 10,000 Person Years		
	1965 Applicants	Attrition Group	Airmen Still Active
Eye			
Critical Pathology	24.8	40.5	23.0
Non-Critical Pathology	21.3	33.2	20.0
Total Pathology	46.1	73.7	43.0
Ears, Nose, Throat & Mouth			
Critical Pathology	0.7	1.3	0.7
Non-Critical Pathology	25.7	35.7	24.6
Total Pathology	26.4	37.0	25.3
Respiratory			
Critical Pathology	0.6	1.7	0.5
Non-Critical Pathology	11.8	21.1	10.8
Total Pathology	12.4	22.8	11.3
Cardiovascular			
Critical Pathology	17.9	90.3	9.9
Non-Critical Pathology	44.3	93.5	38.9
Total Pathology	62.2	183.8	48.8
Abdominal			
Critical Pathology	4.8	9.3	4.3
Non-Critical Pathology	110.6	178.5	103.1
Total Pathology	115.4	187.8	107.4
Neuropsychiatric			
Critical Pathology	3.5	23.1	1.3
Non-Critical Pathology	27.5	70.4	22.7
Total Pathology	31.0	93.5	24.0
Bones and Joints			
Critical Pathology	6.4	11.7	5.8
Non-Critical Pathology	20.1	35.0	18.4
Total Pathology	26.5	46.7	24.2
Muscles			
Critical Pathology	1.9	3.6	1.7
Non-Critical Pathology	1.5	3.5	1.3
Total Pathology	3.4	7.1	3.0
Miscellaneous Conditions			
Critical Pathology	8.0	21.1	6.5
Non-Critical Pathology	44.2	182.7	28.9
Total Pathology	52.2	203.8	35.4
TOTAL			
Critical Pathology	66.7	195.7	52.4
Non-Critical Pathology	269.6	541.8	239.5
Total Pathology	336.3	737.5	291.9

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table XIV

MOST RECENT FAA EXAMINATION AND PATHOLOGY STATUS*
ALL 1965 APPLICANTS

Year	Critical**		Non-Critical**		Without Pathology		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percen
1965	1,893	2.4	9,762	12.1	68,711	85.5	80,366	100.0
Subtotal	1,893	2.4	9,762	12.1	68,711	85.5	80,366	100.0
1966	229	3.5	807	12.4	5,462	84.1	6,498	100.0
1967	1,426	4.0	3,513	9.9	30,569	86.1	35,508	100.0
Subtotal+	1,655	3.9	4,320	10.3	36,031	85.8	42,006	100.0
1968	1,361	3.8	2,055	5.8	32,088	90.4	35,504	100.0
1969	5,131	3.4	6,168	4.2	137,261	92.4	148,560	100.0
Subtotal+	6,492	3.5	8,223	4.5	169,349	92.0	184,064	100.0
TOTAL	10,040	3.3	22,305	7.3	274,091	89.4	306,436	100.0

*Pathology status as of last examination.

**Critical and non-critical codes are identified in the Appendix.

+Subtotals presented here differ slightly from previous totals for attrition and still actives because denials for the last two years are counted under the year of last examination in this table and as attrition in other tables.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

Table XV

ATTRITION GROUP VERSUS ACTIVE AIRMEN
BY CLASS OF MEDICAL CERTIFICATE

Group	First Class *		Second Class *		Third Class *		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percen
Attrition **	5,346	10.5	31,720	27.5	86,679	61.9	123,745	40.4
Active	45,739	89.5	83,618	72.5	53,334	38.1	182,691	59.6
TOTAL	51,085	100.0	115,338	100.0	140,013	100.0	306,436	100.0

*Class of medical certificate determined by class issued code or if denied or pending by class applied for code.

**Attrition includes those originally issued in 1965 whose most recent examination was over 24 calendar months ago as of 1 January 1970; also, includes those denied subsequent to their examination in 1965.

Source: Civil Aeromedical Institute, Aeromedical Certification Branch, Medical Statistical Section.

APPENDIX

CRITICAL MEDICAL CONDITIONS

Eye

Diplopia within 35° (homonymous, vertical heteronymous)
Aphakia (absence of the lens)
Cataract (opacity of lens)
Glaucoma
Fails color signal test
Wears contact lenses
Blindness or absence of either eye (light perception only)

Ear, Nose, Throat & Mouth

Mute
Deaf Mute

Cardiovascular

Myocardial infarction (heart attack, coronary occlusion or thrombosis)
Coronary artery disease—heart disease, includes angina pectoris
Special heart pathology
Fibrillation (auricular)
Hypertension with heart pathology
Hypertension with medication

Abdominal

Complicated ulcer—bleeding, perforation, obstruction, severe pain

Neuropsychiatric

Brain
Vascular—thrombosis, occlusion, stroke, embolism, aneurysm, spasm, hematoma, subdural or epidural hemorrhage, CVA etc.
Convulsive Reactions—epilepsy, grand mal, petit mal
Degenerative—atrophy, multiple sclerosis, chronic brain disease
Spinal Cord
Degenerative—tabes, disseminated sclerosis, ascending paralysis, amyotrophic lateral sclerosis, etc.
Psychotic Disorders (Not Attributed to Physical Condition)
Schizophrenia
Major Affective Disorders
Paranoid States
Other Psychoses
Personality Disorders and Certain Other Non-Psychotic Mental Disorders
A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.
Chronic Alcoholism
Drug Addiction
Mental Deficiences
Mental Deficiency—congenital or acquired

Miscellaneous Conditions

Diabetes, controlled by diet
Diabetes, controlled by insulin
Diabetes, controlled by hypoglycemic drugs (other than insulin)
Collagenous Diseases

Neoplasm

Deformed by Amputation

Deformed by Limitation of Motion