ALTITUDE CHAMBER REACTION REPORT

NAVMED 6410/4 (Rev. 1-72)

NAME AND ADDRESS OF REPORTING STATION			DATE
NAME OF PATIENT *(Surname first)*	GRADE/RATE	SOCIAL SECURITY NO.	TYPE OF REACTION
FLIGHT STARTED *(Date and Time)*	TYPE O_2 MASK USED	TYPE OF REGULATOR USED	
TYPE FLIGHT	RATE OF ASCENT	REGULATOR SETTING ___ NORMAL ___ IOO%	
MAXIMUM ALTITUDE ATTAINED BY PATIENT		PRESSURE SUIT USED ___ YES ___ NO	
ALTITUDE AT ONSET OF SYMPTOMS	DURATION OF TIME AT 30.000 FEET OR ABOVE		
ALTITUDE SYMPTOMS RELIEVED	TOTAL TIME OF PRE-OXYGENATION PRIOR TO FLIGHT		
DESIGNATION OR NEC	ORGANIZATION AND HOME STATION		
AGE WEIGHT _____LBS.	☐ MEASURED ☐ ESTIMATED	HEIGHT _____ INCHES	☐ MEASURED ☐ ESTIMATED

ACTIVITY IN PREVIOUS TWENTY-FOUR HOUR PERIOD

AMOUNT OF SLEEP *(Hrs.)*	PHYSICAL EXERCISE ___ AVERAGE ___ VIGOROUS	ALCOHOL *(Quantity and Time)*

DIET *(Time, quantity & quality)*

LAST AERIAL FLIGHT *(Date)*	DURATION	CABIN ALTITUDE *(Maximum)*
LAST CHAMBER FLIGHT *(Date)*	TYPE AND ALTITUDE *(Max)*	PREVIOUS ALTITUDE REACTIONS *(Date and Type)*
MEDICAL OFFICER IN ATTENDANCE	AEROSPACE PHYSIOLOGIST IN ATTENDANCE	

SIGNS AND SYMPTOMS

SIGNS & SYMPTOMS	INTENSITY (mild, mod., sev.)	ANATOMICAL LOCATION	DURING CHAMBER RUN	AFTER DESCENT
LOCALIZED JOINT PAIN				
CHOKES				
SKIN LESIONS				
MUSCULAR WEAKNESS				
PARESTHESIA				
PARALYSIS				
VISUAL DISTURBANCES				
CYANOSIS				
APPREHENSION				
DIZZINES				
NUMBNESS				
MUSCLE SPASM				
MENTAL CONFUSION				
UNCONSCIOUSNESS				
HYPERVENTILATION				
HEADACHE				
NAUSEA OR VOMITING				
CONVULSIONS				
ABDOMINAL DISTENSION *(Pain)*				
AEROTITIS				
AEROSINUSITIS				

DETAILED NARRATIVE SUMMARY

(Include sequence of events preceding the reaction of other signs and symptoms before, during and following treatment and subsequent result of treatment, noting any unusual contributing factors. Use continuation sheet if needed)

DIAGNOSIS *(Code description)*

ADMISSION TO HOSPITAL *(Date & Time)*	MEDICAL FACILITY
REASON FOR HOSPITALIZATION	
___ ABNORMALITIES AFTER 2 HOUR OBSERVATION	___ OBSERVATION
___ SEVERITY OF SYMPTOMS	___ OTHER *(Specify)* _____
RELEASE FROM HOSPITAL *(Date and Time)*	DISPOSITION ___ DUTY ___ OTHER
SIGNATURE OF AEROSPACE PHYSIOLOGIST	SIGNATURE OF ATTENDING FLIGHT SURGEON