

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION

Driver completes this section.

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	New Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	Date of Exam
Address	City, State, Zip Code	Work Tel: () () Home Tel: () ()	Driver License No.	License Class <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue	

2. HEALTH HISTORY

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes No	Yes No	Yes No
<input type="checkbox"/> Any illness or injury in the last 5 years? <input type="checkbox"/> Head/Brain injuries, disorders or illnesses <input type="checkbox"/> Seizures, epilepsy <input type="checkbox"/> medication _____ <input type="checkbox"/> Eye disorders or impaired vision (except corrective lenses) <input type="checkbox"/> Ear disorders, loss of hearing or balance <input type="checkbox"/> Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication _____ <input type="checkbox"/> Heart surgery (valve replacement/by-pass, angioplasty, pacemaker) <input type="checkbox"/> High blood pressure <input type="checkbox"/> medication _____ <input type="checkbox"/> Muscular disease <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis <input type="checkbox"/> Kidney disease, dialysis <input type="checkbox"/> Liver disease <input type="checkbox"/> Digestive problems <input type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication _____ <input type="checkbox"/> Loss of, or altered consciousness	<input type="checkbox"/> Fainting, dizziness <input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring <input type="checkbox"/> Stroke or paralysis <input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe <input type="checkbox"/> Spinal injury or disease <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> Regular, frequent alcohol use <input type="checkbox"/> Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature _____ Date _____

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)
