

MEDICAL EXAMINATION REPORT - For Commercial Driver Fitness Determination

1.	Driver's Information	Driver must complete this section. Please print legibly	Date of Exam: _____
		Check Type of Exam <input type="checkbox"/> New Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow-up	Sex <input type="checkbox"/> M <input type="checkbox"/> F

Print Name (Last, First, Middle): _____ Date of Birth ____/____/____

Social Security Number: - - Age: _____ Work Tel: (____) _____ - _____ Home Tel: Work Tel: (____) _____ - _____

Street _____

City _____ State _____ Zip Code _____

Driver's License Number: _____ State of Issue: _____

License Class – Check one
 A C Other
 B D Specify _____

2.	Health History	Driver must complete this section, but medical examiner is encouraged to discuss with driver.
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Yes	No		Yes	NO		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorders or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders, pauses in breathing while asleep,
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease			daytime sleepiness, loud snoring
		<input type="checkbox"/> Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by:	<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance			<input type="checkbox"/> Diet	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack, other cardiovascular condition			<input type="checkbox"/> Pills	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
		<input type="checkbox"/> Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g., severe depression	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure			<input type="checkbox"/> Medication _____			
		<input type="checkbox"/> Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Loss of, or altered consciousness			
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease						
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath						

For any **YES** answer above, 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.)
