

# Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

## 1. DRIVER'S INFORMATION

Driver completes this section

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

## 2. HEALTH HISTORY

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

<p><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>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 _____</p> <p>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 _____</p> <p>Heart surgery (valve replacement/bypass, angioplasty, pacemaker)  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Muscular disease  <input type="checkbox"/> Shortness of breath</p>	<p><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>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 _____</p> <p>Loss of, or altered consciousness  <input type="checkbox"/> _____</p>
<p><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>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</p>	

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.)

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