

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

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|--|--|---|--|--|---------------|--------------------|---|---|----------------|
| 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 Recertification Follow-up <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Date of Exam |
| Address | | City, State, Zip Code | | Work Tel: () | Home 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 |
| 2. HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver. | | | | | | | | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Any illness or injury in the last 5 years? Head/Brain injuries, disorders or illnesses Seizures, epilepsy <input type="checkbox"/> medication _____ Eye disorders or impaired vision (except corrective lenses) Ear disorders, loss of hearing or balance Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication _____ Heart surgery (valve replacement/bypass, angioplasty, pacemaker) High blood pressure <input type="checkbox"/> medication _____ Muscular disease Shortness of breath | | Yes <input type="checkbox"/> No <input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis Kidney disease, dialysis Liver disease Digestive problems Diabetes or elevated blood sugar controlled by: diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> medication _____ Nervous or psychiatric disorders, e.g., severe depression Loss of, or altered consciousness <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting, dizziness Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring Stroke or paralysis Missing or impaired hand, arm, foot, leg, finger, toe Spinal injury or disease Chronic low back pain Regular, frequent alcohol use 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.)
