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 ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam

Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )	Driver License No.	License Class ☐ A ☐ B ☐ C ☐ D ☐ Other	State of Issue

2. HEALTH HISTORY

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

Yes No

- Any illness or injury in the last 5 years?
- Head/Brain injuries, disorders or illnesses
- Seizures, epilepsy
  - medication_____
- Eye disorders or impaired vision (except corrective lenses)
- Ear disorders, loss of hearing or balance
- Heart disease or heart attack; other cardiovascular condition
  - medication_____
- Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
- High blood pressure
- Muscular disease
- Shortness of breath

Yes No

- Lung disease, emphysema, asthma, chronic bronchitis
- Kidney disease, dialysis
- Liver disease
- Digestive problems
- Diabetes or elevated blood sugar controlled by:
  - diet
  - pills
  - insulin
- Nervous or psychiatric disorders, e.g., severe depression
  - medication_____
- Loss of, or altered consciousness

Yes No

- 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.

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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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