# 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 ☐ medication_____
- ☐ ☐ 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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