

**MEDICAL EXAMINATION REPORT FOR COMMERCIAL DRIVER FITNESS DETERMINATION**

Driver's Name (First, Last, 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    _ C _ B    _ D _ Other	State of Issue

<p><b><i>Do you now or have you ever had:</i></b></p> <p>Yes    No</p> <p><input type="checkbox"/>    <input type="checkbox"/> Any illness or injury in the last 5 years?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Head/brain injuries, disorders or illnesses?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Seizures, epilepsy? List medication(s) _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Eye disorders or impaired vision (except corrective lenses)?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ear disorders, loss of hearing or balance?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Heart disease or heart attack: other cardiovascular condition?</p> <p><input type="checkbox"/>    <input type="checkbox"/> List medication(s) _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Heart surgery (valve replacement, angioplasty, pacemaker)?</p> <p><input type="checkbox"/>    <input type="checkbox"/> High blood pressure? List medication(s) _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Muscular disease?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Shortness of breath?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Kidney disease, dialysis?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Liver disease?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Digestive problems?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Diabetes or elevated blood sugar controlled by:</p> <p>          <input type="checkbox"/> diet    <input type="checkbox"/> pills    <input type="checkbox"/> insulin</p> <p><input type="checkbox"/>    <input type="checkbox"/> List medication(s) _____</p>	<p><b><i>Do you now or have you ever had:</i></b></p> <p>Yes    No</p> <p><input type="checkbox"/>    <input type="checkbox"/> Nervous or psychiatric disorders such as severe depression?</p> <p><input type="checkbox"/>    <input type="checkbox"/> List medication(s) _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Loss or alteration of consciousness?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Fainting or dizziness?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Stroke or paralysis?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Spinal injury or disease?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Chronic low back pain?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Regular, frequent alcohol use?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Narcotic or habit forming drug use?</p> <p><input type="checkbox"/>    <input type="checkbox"/> Tobacco product use? How much? _____</p>
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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 the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and Medical Examiner's Certificate.

Driver's signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Examiners 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.)*

## TESTING (Medical Examiner completes sections 3 through 7)

### SECTION 3 - VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

*INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet a denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.*

Numerical Readings must be provided

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
R EYE	_____	_____	_____
L EYE	_____	_____	_____
BOTH EYES	_____	_____	_____

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors?  Yes  No

Monocular vision?  Yes  No

Complete next line only if vision testing is done by an ophthalmologist or optometrist.

Date	Name of ophthalmologist or optometrist (print)	Signature	License # /State of issue	Telephone
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Meets Standard?  Yes  No

Applicant meets visual acuity requirement only when wearing corrective lenses?  Yes  No

### SECTION 4 - HEARING

Standard: Must first perceive forced whispered voice greater than or equal to 5' with or without hearing aid, or b) average hearing loss in better ear less than or equal to 40 dB.

*INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.*

Numerical readings must be recorded

Record distance form individual at which forced whispered voice can first be heard. Right ear \_\_\_\_\_ feet Left ear \_\_\_\_\_ feet

Hearing aid used for test?  Yes  No

If audiometer is used, record hearing loss in decibels according to ANSI ZZ24.5-1951.

R ear	_____ 500Hz	_____ 1000 Hz	_____ 2000 Hz	_____ Average
L ear	_____ 500Hz	_____ 1000 Hz	_____ 2000 Hz	_____ Average

Meets standard?  Yes  No

Hearing aid required to meet standard?  Yes  No

### SECTION 5 - BLOOD PRESSURE/PULSE RATE

Numerical readings must be recorded.

Blood pressure \_\_\_\_\_ systolic \_\_\_\_\_ diastolic Pulse rate \_\_\_\_\_ beats per minute \_\_\_\_\_ regular \_\_\_\_\_ irregular Pulse rate after exercise \_\_\_\_\_

*Driver qualified if less than or equal to 140/90 on initial exam.*

**Stage 1 HTN:** *If blood pressure is 140-159 systolic and/or 90-99 diastolic, qualify for one year. If subsequent exam is  $\leq$ 140/90, recert annually. If subsequent exam  $\leq$ 160/100 give a one time extension for 3 mos.*

**Stage 2 HTN:** *If blood pressure is 160-179 systolic and/or 100-109 diastolic on initial exam, qualify for three months only. If within 3 months blood pressure is less than or equal to 140/90, then qualify for 1 year. Documentation of treatment and control must be provided within 90 days from time of initial exam. If blood pressure remains controlled, may certify for up to 12 months at a time.*

**Stage 3 HTN:** *If blood pressure greater than 180 systolic and/or 110 diastolic on initial exam, the driver is not qualified until reduced to less than 140/90. The driver may not be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may then be certified for 6 months and biannually thereafter if a recheck blood pressure is 140/90.*

Meets standard?  Yes  No

### SECTION 6 - LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Urine specimen \_\_\_\_\_ specific gravity \_\_\_\_\_ protein \_\_\_\_\_ blood \_\_\_\_\_ sugar

Other testing (describe and record)

### SECTION 7 - PHYSICAL EXAMINATION

Height \_\_\_\_\_ inches Weight \_\_\_\_\_ pounds

*The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.*

BODY SYSTEM	CHECK FOR:	YES (abnl)	NO (nl)
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General appearance Eyes	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse. Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.		
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