DOT MEDICAL EXAM INFORMATION SHEET
**Please email **

SOCIAL Security Number:_____ Birthdate:_____Age:_____New Cert_____Re-Cert_____

FIRST Name: MIDDLE Name LAST Name

FULL Address:_____City_____State_____Zip_____

Home Phone_____ Work Phone_____

***Current* DL#_____License Class (A, B, C, D):_____State of issue_____DL# *Expiration* Date_____**

Height:_____Weight _____

Sex: Male Female_ Eye Color Hair Color

Health History: Must check a "yes" or "no" to each question:

Yes_ No____**Any illness or injury in last 5 yrs**. if yes, please explain:_____
Yes_ No____Head/Brain injury, disorders
Yes_ No Seizures, Epilepsy. If yes, Medication
Yes_ No Eye disorders or impaired vision (***except Corrective lenses/Glasses***)
Yes_ No Ear disorders, loss of hearing or balance
Yes_ No **Heart disease** or heart attack, other cardiovascular condition. If yes, Medication ____
Yes_ No **Heart surgery (valve replacement, bypass, angioplasty, pacemaker**) If yes, Last stress test done:____
Yes_ No **High Blood Pressure**. If yes, Medication: ____
Yes_ No Muscular Disease
Yes_ No Shortness of breath
Yes_ No Lung disease**, asthma,** emphysema, chronic bronchitis. If yes, Medication
Yes_ No Kidney disease, dialysis
Yes_ No Liver Disease
Yes_ No Digestive Problems, GERD
Yes_ No____**Diabetes** or elevated blood sugar controlled by: Diet_____Pills_____Insulin_____**Medications**:_____
Yes_ No____**Nervous or Psychiatric disorders**, e.g., **Depression**, Anxiety etc.. If yes**, Medication**_____
Yes_ No____Loss of or altered consciousness
Yes_ No Fainting, Dizziness
Yes_ No____**Sleep Disorders**, pauses in breathing while sleeping, loud snoring, **sleep apnea**
Yes_ No Stroke or paralysis
Yes_ No Missing or impaired hand, arm, foot, leg, finger, toe. If yes, what area of the body
Yes_ No Spinal Injury or disease
Yes_ No Chronic low back pain
Yes_ No Regular, frequent alcohol use
Yes_ No Narcotic or habit forming drug use

Any other medications:
Any other medical problems/history not mentioned above:
***For any YES answers*, indicate when you were diagnosed, your doctor's name and address, and if any current limitations**:_

I hereby give permission to the DOT medical examiner to store all documents of this exam and review all of my prior DOT medical exam documents within the Road Ready database. I certify (or declare) under penalty of perjury that the foregoing is true and correct. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiners Certification.

Driver's Signature: _ Date: _____

Staff use:

SG Protein Blood Sugar_ Accu-check if indicated

Examiner Qualified: yes_ Card Expiration Date Temp DQ _ if yes, Reason:_

Comments: