# 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**

### Sex: Male Female\_ Eye Color Hair Color

**Height: Weight**

**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: