

DMV USE ONLY
<input type="checkbox"/> Updated by _____

PHYSICIAN'S HEALTH REPORT

DO NOT use this form for Commercial Licensing Requirements.

PHYSICIAN'S INSTRUCTIONS: Please complete the form and check "Yes" or "No" to each question and explain any "Yes" answer(s) in the space provided on the form, or on another piece of paper. **Applicant must submit a completed health questionnaire every two years. Exception: Driving School Instructors must complete a health questionnaire every three years.**

SECTION 1 — PATIENT INFORMATION

TRUE FULL NAME	DATE OF BIRTH	DRIVER LICENSE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
DAYTIME PHONE ()		

SECTION 2 — HEALTH QUESTIONS

- | | | YES | NO |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Does patient have difficulty recognizing the colors of red, green, and amber used in traffic signal lights and devices? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is patient's side (peripheral) vision less than 70° for either eye? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does patient have difficulty perceiving a forced whispered voice in the patient's better ear, with or without a hearing aid, at not less than five (5) feet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does patient have an acuity impairment in either eye that is not correctable to visual acuity of 20/40 or better? ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does patient: | | | |
| a. Have a missing foot, leg, hand, finger or arm? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have any impairment of a hand, finger, arm, foot, leg or any other limitation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does patient have diabetes requiring insulin? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Has patient had a hypoglycemic episode or any other adverse reaction related to diabetes in the last three (3) years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has patient had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," has patient had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last three (3) years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has patient been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," is patient's respiratory condition likely to interfere with patient's ability to drive a motor vehicle safely? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has patient been diagnosed with high blood pressure of 140/90 or higher? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has patient ever been diagnosed with rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has patient been diagnosed with any mental, nervous, organic or functional disease, or psychiatric disorder?.... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has patient been diagnosed with epilepsy or any other condition that may cause lapse of consciousness or loss of control? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," has there been a lapse of consciousness or loss of control in the last three (3) years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does patient use a controlled substance, amphetamine, narcotic, or any other habit-forming drug? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes" will the drug interfere with the patient's ability to drive a motor vehicle safely? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does patient have a history or diagnosis of alcoholism? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PHYSICIAN'S HEALTH REPORT (CONT.)

Visual Acuity: Must be at least 20/40 in each eye with/without corrective lenses.

UNCORRECTED	CORRECTED	CONTACTS?
Both	20/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left	20/___	Are the lenses well adapted and tolerated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Right	20/___	

Blood Pressure: If consistently 140/90 mm. Hg. or higher, further tests may be necessary to determine if driver is qualified.

Systolic	Diastolic
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EXPLAIN ANY "YES" ANSWERS HERE

I have examined the applicant and found that the patient has no physical impairment or condition that would preclude them from: Driving a House Car 40+ feet Being a Driving School Instructor

PHYSICIAN'S NAME (PLEASE PRINT)		DATE OF LAST VISIT
PHYSICIAN'S OFFICE ADDRESS		Mo. _____ Year _____
PHYSICIAN'S SIGNATURE		PHYSICIAN'S PHONE NUMBER ()
X	DATE OF EXAM	LICENSE OR CERTIFICATE NUMBER/ISSUING STATE

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I hereby give consent to the release of medical information by the above named physician.

DRIVER'S SIGNATURE		DATE
X		
DMV USE X	EXAMINER'S SIGNATURE	ID NUMBER
		OFFICE
		DATE