STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

546

HEALTH QUESTIONNAIRE

DO NOT use this form for Commercial Licensing Requirements.

DMV USE ONLY
☐ Updated by _____

The applicant completes this form.

INSTRUCTIONS: Please check "Yes" or "No" to each question and explain any "Yes" answer(s) in the space provided on the bottom of the form, or on another piece of paper. If you are not sure how to answer a specific question, please contact your physician for assistance. "Yes" answers to any question may require DMV to contact your physician about your medical qualifications before DMV can issue you a license. **You must submit a completed health questionnaire every two years.**

PLEASE TELL US ABOUT YOURSELF:

TRUE FULL NAME

ADDRESS

DATE OF BIRTH	DRIVER LICENSE NUMBER	DAYTIME PHONE
Mo_____ Day_____ Year_____		( )

HEALTH QUESTIONS

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

EXPLAIN ANY "YES" ANSWERS HERE.

PHYSICIAN'S NAME *(PLEASE PRINT)*	DATE OF LAST VISIT
	Mo_____ Year_____
PHYSICIAN'S OFFICE ADDRESS	PHYSICIAN'S PHONE NUMBER
	( )

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	EXAMINER'S SIGNATURE	ID NUMBER	OFFICE	DATE
	X			