DOT/CDL Physical Exam Questionnaire

Due to stricter federal requirements, this facility may not able to perform your exam depending on your answer of the following questions. Do you have any of the following conditions?

HEART

Condition	Yes	No
Implanted defibrillator	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Medication for irregular heart beat	☐ Yes	☐ No
Intermittent Claudication	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No

NEUROLOGICAL

Condition	Yes	No
Meniere's Disease	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Labyrinth Fistula	☐ Yes	☐ No
History of Seizures	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
Frequent Migraine Headaches	☐ Yes	☐ No
Peripheral Neuropathy	☐ Yes	☐ No

MEDICATION

Condition	Yes	No
Allergic to Medications Please list:	☐ Yes	☐ No
Do you take any medications Please list:	☐ Yes	☐ No

EYES

Condition	Yes	No
Macular Degeneration	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataract	☐ Yes	☐ No
Retinopathy	☐ Yes	☐ No
Missing lens	☐ Yes	☐ No

LUNG

Condition	Yes	No
Pulmonary Hypertension	☐ Yes	☐ No
(COPD or Emphysema)	☐ Yes	☐ No
Asthma/wheezing, chronic cough	☐ Yes	☐ No
Passing out from coughing	☐ Yes	☐ No
Untreated Sleep Apnea	☐ Yes	☐ No
Starting on CPAP less than 30 days ago	☐ Yes	☐ No
Excessive Daytime Sleepiness	☐ Yes	☐ No
Smoker over the age of 35 years *	☐ Yes	☐ No
Treatment with CPAP or BIPAP machine **	☐ Yes	☐ No

METABOLIC / DIABETES

Condition	Yes	No
Extreme Obesity ***	☐ Yes	☐ No

PSYCHIATIC

Condition	Yes	No
Suicidal thoughts	☐ Yes	☐ No
Hallucinations: Visual or hearing voices	☐ Yes	☐ No

KIDNEY

Condition	Yes	No
On Renal Dialysis or do you have Chronic Kidney Failure	☐ Yes	☐ No

1. Smokers over the age of 35 years old will need to bring in a "Pulmonary Function Test" *
2. Persons with Sleep Apnea need a printout of their CPAP machine for the past 2 months.**
3. If your weight is excessive for your height (BMI greater than 39) you will need clearance from your provider. ***
4. If you neck size is 17.5 inches or larger, you may need a sleep apnea study.

Our clinic follows the guidelines set forth by the Federal Motor Carrier Safety Administration. Your signature below implies that that you have provided accurate information on your certificate questionnaires. By signing here you understand and accept that once the examination has begun by one of our certified medical providers, the exam must be completed. Lastly, you agree that regardless of the findings and recommendations by the examiner, no refunds will be issued for this visit. The medical examiner may issue a certificate for less than 24 months when it is necessary for monitoring a condition, such as high blood pressure, or otherwise complying with the Guidelines set out by the Federal Motor Carrier Safety Administration. (FMCSA, 2015).

Print Name	Signature	Date

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD # ____________________ *(or sticker)*

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: ______ First Name: ______ Middle Initial: ___ Date of Birth: ______ Age: ___

Street Address: ______ City: ______ State/Province: ______ Zip Code: ______

Driver's License Number: ______ Issuing State/Province: ______ Phone: ______ Gender: ◯ M ◯ F

E-mail *(optional)*: ______ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: ______

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: ____________ First Name: ____________ DOB: ____________ Exam Date: ____________

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:

	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: ____________ Date: ____________

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)