



**DMV USE ONLY**  
 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.

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

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

Systolic	Diastolic
----------	-----------

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 (     )
<b>X</b>	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	
<b>X</b>			
<b>DMV USE</b>	EXAMINER'S SIGNATURE	ID NUMBER	OFFICE
<b>X</b>			DATE