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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: _____

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)*? **Yes** **No** **Not Sure**
If "yes," please describe below.

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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

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).