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)*? 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)*