Application for Driver's Medical Certificate

This certifies (full name and address)

_____

_____

DOB	Height	Weight	Hair	Eyes	Sex

Please return completed form to registration with receipt from doctor's office visit

Yes	No	
		Head or spinal injuries
		Seizures, fits, convulsions, or fainting
		Extensive confinement by illness or injury
		Cardiovascular disease
		Tuberculosis
		Syphilis
		Gonorrhea
		Diabetes
		Gastrointestinal ulcer
		Nervous stomach
		Rheumatic fever
		Asthma
		Kidney disease
		Muscular disease
		Any other disease_____
		Permanent defect from illness disease or injury
		Psychiatric disorder
		Any other nervous disorder

PHYSICAL EXAMINATION

General Appearance and development:
Good: _____ Fair: _____ Poor: _____

Vision: For distance: Right: 20/_____ Left: 20/_____ ____with corrective lenses ___without corrective lenses
Evidence of disease or injury: Right _____ Left _____ Color test _____
Horizontal field of vision: Right _____ Left _____

Hearing: Right ear _____ Left ear _____ disease or injury _____

Throat: _____

Thorax: Heart_____ If organic disease is present, is it fully compensated?_____
Blood Pressure: Systolic _____ Diastolic_____ Pulse: before exercise _____ immediately after exercise _____
Lungs: _____

Abdomen: Scars: _____ Abnormal mass(s) _____ Tenderness _____
Hernia: No ____ Yes ___ If yes, where? _____ is truss worn? _____

Gastrointestinal: Ulceration or other disease? No ___ Yes___ describe: _____

Reflexes: Romberg _____ Pupillary _____ Light Right _____ Left _____
Accommodation: Right _____ Left _____
Knee jerk: Right: Normal___ Increased___ Absent ___ Left: Normal___ Increased ___ absent ___
Remarks: _____

Extremities: Upper_____ Lower _____ Spine_____

Lab and other Urine: Spec. gr _____ Alb _____ sugar _____ Other lab data (serology etc.) _____

Special findings: Radiology data: _____Electrocardiograph _____

General comments: _____

_____ _____ _____
Date of exam *Printed name of applicant* *Signature of applicant*

_____ _____
Street address of examining physician *Printed name of examining physician*

_____ _____
City, State, Zip of examining physician *Signature of examining physician*

☐ *CHECK HERE IF NOT QUALIFIED*