APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE

RECEIPT FROM DOCTOR'S OFFICE IS REQUIRED

THIS CERTIFIES (FULL NAME AND ADDRESS)

D.O.B	Height	Weight	Hair	Eyes	Sex

Social Security Number:

RECEIPT FROM DOCTOR'S OFFICE REQUIRED

If answer to any of the medical history is yes, explain:

_____

_____

_____

_____

MEDICAL HISTORY

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/_____

_____ Without corrective lenses _____ With corrective lenses, if worn

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(es) _____ Tenderness _____

Hernia: No _____ Yes _____ If yes, where? _____ Is truss worn? _____

GASTROINTESTINAL:

Ulceration or other disease? No ____ Yes (Describe) _____

REFLEXES: Romberg _____ Pupillary _____ Light R _____ L _____

Accomodation: Right _____ Left _____

Knee Jerk: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Remarks _____

EXTREMETIES:

Upper _____ Lower _____ Spine _____

LABORATORY AND OTHER SPECIAL FINDINGS:

Urine: Spec. Gr._____ Alb. _____ Sugar _____

Other laboratory data (serology, etc.) _____

Radiological data: _____ Electrocardiograph _____

GENERAL COMMENTS: _____

_____

_____ (Street/PO Box of examining doctor)

_____ (Name of examining doctor) (Print)

_____ (Date of Examination)

_____ (City, State, Zip of examining doctor)

_____ (Signature of examining doctor)

_____ (Name of applicant) (Print)

_____ (Signature of applicant)

CHECK HERE IF NOT QUALIFIED ☐