Medical Examination Report
FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION Driver completes this section

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam

Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )	Driver License No.	License Class ☐ A ☐ B ☐ C ☐ D ☐ Other	State of Issue

2. HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No		Yes	No		Yes	No	
☐	☐	Any illness or injury in the last 5 years?	☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Fainting, dizziness
☐	☐	Head/Brain injuries, disorders or illnesses	☐	☐	Kidney disease, dialysis	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Seizures, epilepsy ☐ medication_____	☐	☐	Liver disease	☐	☐	Stroke or paralysis
☐	☐	Eye disorders or impaired vision (except corrective lenses)	☐	☐	Digestive problems	☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin	☐	☐	Spinal injury or disease
☐	☐	Heart disease or heart attack; other cardiovascular condition ☐ medication_____	☐	☐	Nervous or psychiatric disorders, e.g., severe depression medication_____	☐	☐	Chronic low back pain
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	Loss of, or altered consciousness	☐	☐	Regular, frequent alcohol use
☐	☐	High blood pressure ☐ medication_____				☐	☐	Narcotic or habit forming drug use
☐	☐	Muscular disease						
☐	☐	Shortness of breath						

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

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I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature_____ Date_____

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

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