

Public Burden Statement

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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)? 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:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses <i>(e.g., concussion)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Seizures/epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Eye problems <i>(except glasses or contacts)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lung disease <i>(e.g., asthma)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test <i>(e.g., sleep apnea)?</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insulin used	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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