



APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE

RECEIPT FROM DOCTOR'S OFFICE IS REQUIRED

MEDICAL HISTORY

THIS CERTIFIES (FULL NAME AND ADDRESS)					
D.O.B	Height	Weight	Hair	Eyes	Sex
Social Security Number:					

Yes	No
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- Head or spinal injuries
- Seizures, fits convulsions or fainting
- Extensive confinement by illness or injury
- Cardiovascular disease
- Tuberculosis
- Syphilis
- Gonorrhoea
- 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

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

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 _____

Accommodation: Right _____ Left _____

Knee Jerk: Right: Normal _____ Increased _____ Absent _____

Left: Normal _____ Increased _____ Absent _____

Remarks _____

EXTREMITIES:

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