

PHYSICIAN'S HEALTH REPORT
 DO NOT use this form for Commercial Licensing Requirements.

546A

DMV USE ONLY
 Updated by _____

PHYSICIAN'S INSTRUCTIONS: Please complete the form and check "Yes" or "No" to each question and explain any "Yes" answer(s) in the space provided on the bottom of the form, or on another piece of paper. **Applicant must submit a completed health questionnaire every two years. Exception: Driving School Instructors must complete a health questionnaire every three years.**

PATIENT INFORMATION:

TRUE FULL NAME	DATE OF BIRTH / /	DRIVER LICENSE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
		DAYTIME PHONE ()

HEALTH QUESTIONS

	YES	NO
1. Does patient have difficulty recognizing the colors of red, green, and amber used in traffic signal lights and devices?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is patient's side (peripheral) vision less than 70° for either eye?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does patient have difficulty perceiving a forced whispered voice in the patient's better ear, without a hearing aid, at not less than five (5) feet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does patient have an acuity impairment in either eye that is not correctable to visual acuity of 20/40 or better?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does patient:		
a. Have a missing foot, leg, hand, finger or arm?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have any impairment of a hand, finger, arm, foot, leg or any other limitation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does patient have diabetes requiring insulin for control?.....	<input type="checkbox"/>	<input type="checkbox"/>
a. Has patient had a hypoglycemic episode or any other adverse reaction related to diabetes in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has patient had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," has patient had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has patient been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," is patient's respiratory condition likely to interfere with patient's ability to drive a motor vehicle safely?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has patient been diagnosed with high blood pressure of 140/90 or higher?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has patient ever been diagnosed with rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease? .	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Has patient been diagnosed with any mental, nervous, organic or functional disease, or psychiatric disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Has patient been diagnosed with epilepsy or any other condition that may cause loss of consciousness or loss of control?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," has there been a loss of consciousness or loss of control in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does patient use a controlled substance, amphetamine, narcotic, or any other habit-forming drug?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes" will the drug interfere with the patient's ability to drive a motor vehicle?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Does patient have a history or diagnosis of alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>

Visual Acuity: Must be at least 20/40 in each eye with/without corrective lenses.

UNCORRECTED	CORRECTED	CONTACTS?
Both 20/___	20/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left 20/___	20/___	Are the lenses well-adapted and tolerated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Right 20/___	20/___	

Blood Pressure: If consistently 140/90 mm. Hg. or higher, further tests may be necessary to determine if driver is qualified.

Systolic	Diastolic
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EXPLAIN ANY "YES" ANSWERS HERE.

I have examined the above applicant and find that the patient has no physical impairment or condition that would preclude them from:
 Driving a House Car 40+ ft. Being a Driving School Instructor

PHYSICIAN'S NAME (PLEASE PRINT)	DATE OF LAST VISIT Mo _____ Year _____
PHYSICIAN'S OFFICE ADDRESS	PHYSICIAN'S PHONE NUMBER ()
PHYSICIAN'S SIGNATURE X	DATE OF EXAM
	LICENSE OR CERTIFICATE NUMBER/ISSUING STATE

I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct and I hereby give consent to the release of medical information by the above named physician.

DRIVER'S SIGNATURE X	DATE
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DMV USE	EXAMINER'S SIGNATURE X	ID NUMBER	OFFICE	DATE
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