



# DRIVER MEDICAL EVALUATION

(Medical information is CONFIDENTIAL under Section 1808.5 CVC)

**PHYSICIAN RETURN FORM TO:**  
**DEPARTMENT OF MOTOR VEHICLES**  
Licensing Operations Division  
Driver Safety Branch  
P. O. Box 934345 MS J-234  
Sacramento, CA 95818

**INSTRUCTIONS TO THE DRIVER:** Please take this form to the medical professional most familiar with your health history and current medical condition. **Before** giving this form to your medical professional, complete and sign Sections 1-3. **PLEASE PRINT LEGIBLY.**

**INSTRUCTIONS TO THE MEDICAL PROFESSIONAL:** Please complete Sections 5-13, on pages 2 through 5. The Department of Motor Vehicles' records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. In this case, the department is concerned about the following condition:

RETURN BY:

## 1. DRIVER INFORMATION

NAME (LAST, FIRST, MIDDLE)		DRIVER LICENSE NO.	BIRTH DATE	FIELD FILE
STREET ADDRESS		CITY	ZIP	PATIENT'S DAYTIME OR HOME PHONE NO.

### DRIVER MUST COMPLETE HEALTH HISTORY BELOW. (Please explain any "YES" answers)

YES	NO		YES	NO	
		Head, neck, spinal injury, disorders or illnesses			Kidney disease, stones, blood in urine, or dialysis
		Seizure, convulsions, or epilepsy			Muscular disease
		Dizziness, fainting, or frequent headaches			Any permanent impairment
		Eye problem (except corrective lenses)			Nervous or psychiatric disorder
		Cardiovascular (heart or blood vessel) disease			Regular or frequent alcohol use
		Heart attack, stroke, or paralysis			Problems with the use of alcohol or drugs
		Lung disease (include tuberculosis, asthma or emphysema)			Other disorders or diseases
		Nervous stomach, ulcer, or digestive problems			Any major illness, injury, or operations in last 5 years
		Diabetes or high blood sugar			Currently taking medications

**EXPLANATION:** (Include onset date, diagnosis, medication, doctor's name and address and any current condition or limitation. Attach additional sheet, if needed).

**I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I further certify that all information concerning my health is true and correct.**

DATE	DRIVER'S SIGNATURE <b>X</b>
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## 2. DRIVER'S ADVISORY STATEMENT

Medical information is required under the authority of Divisions 6 and 7 of the California Vehicle Code. Failure to provide the information is cause for refusal to issue a license or to withdraw the driving privilege.

All records of the Department of Motor Vehicles, relating to the physical or mental condition of any person, are confidential and not open to public inspection (California Vehicle Code Section 1808.5). Information used in determining driving qualifications is available to you and/or your representative with your signed authorization.

*The department has sole responsibility for any decision regarding your driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.*

## 3. MEDICAL INFORMATION AUTHORIZATION

MEDICAL PROFESSIONAL, HOSPITAL, OR MEDICAL FACILITY (NAME AND ADDRESS)

DATE	MEDICAL RECORD/PATIENT FILE NO.
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**I hereby authorize** my medical professional or hospital to answer any questions from the Department of Motor Vehicles, or its employees, relating to my physical or mental condition, and/or drug and/or alcohol use, and to release any related information or records to the Department of Motor Vehicles or its employees. Any expense involved is to be charged to me and not to the Department of Motor Vehicles.

**I hereby authorize** the Department of Motor Vehicles to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

**NOTE:** You may wish to make a copy of the completed Driver Medical Evaluation for your records.

SIGNED <b>X</b>	DATE
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**SECTIONS 5 -13 TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE**

**4. MEDICAL PROFESSIONAL'S MEDICAL EVALUATION INSTRUCTIONS**

**INSTRUCTIONS TO THE MEDICAL PROFESSIONAL (MP):** The Department of Motor Vehicles' records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. (See Instructions to the Medical Professional, page 1 for the specific medical condition that is a concern to the department.) With your assistance, the department hopes to resolve the matter with a minimum of inconvenience to all concerned. The Health History and Medical Information Authorization sections on page 1 must be completed and signed by the patient before you complete this Driver Medical Evaluation form.

Your experience and knowledge of the patient's condition, results of medical examinations and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. PLEASE ANSWER ALL QUESTIONS on this form. If questions do not apply, indicate "N/A". You may furnish a narrative report if you prefer, but please include all information pertinent to your patient. The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

**5. VISION**

<b>VISUAL ACUITY (without bioptic telescope)</b>	<b>BOTH EYES</b>	<b>RIGHT EYE</b>	<b>LEFT EYE</b>
Without Lenses	20/	20/	20/
With Present Lenses	20/	20/	20/
ANY EYE INJURY OR DISEASE? (LIST)		IS FURTHER EYE EXAMINATION SUGGESTED? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**6. TREATMENT BY OTHER MEDICAL PROFESSIONAL(S)**

IS THIS PATIENT BEING TREATED FOR ANY CONDITION BY ANOTHER MP?

Yes  No

IF YES, PLEASE INDICATE NAME OF TREATING MP(S)

CONDITION BEING TREATED

**7. TREATMENT UNDER YOUR SUPERVISION**

DIAGNOSIS (IF THE DIAGNOSIS IS A DISORDER CHARACTERIZED BY LAPSES OF CONSCIOUSNESS, DEMENTIA, OR DIABETES, COMPLETE PAGE 3,4 OR 5.)

DO YOU NEED TO SEE YOUR PATIENT AT REGULAR INTERVALS? IF YES, HOW OFTEN?

Yes  No

**PROGNOSIS**

IS THE CONDITION

Improving  Stable  Worsening or deteriorating  Subject to change

(IF MULTIPLE CONDITIONS, PLEASE DESCRIBE STATUS AND PROGNOSIS IN COMMENTS BELOW.)

MANIFESTATIONS (SYMPTOMS):

(PRESENT)

(PAST)

MAY CONDITION IMPAIR VISION?

Yes  No

HOW LONG HAS THIS PERSON BEEN YOUR PATIENT?

DATE OF LAST EXAMINATION

IS YOUR PATIENT UNDER A CONTROLLED MEDICAL PROGRAM?

Yes  No

HOW LONG HAS CONTROL BEEN MAINTAINED?

IS THE PATIENT ADHERING TO THE MEDICAL REGIMEN?

Yes  No If no, please explain:

IS THE PATIENT KNOWLEDGEABLE ABOUT THE MEDICAL CONDITION?

Yes  No

LIST THE MEDICATIONS PRESCRIBED. PLEASE INCLUDE DOSAGE AND FREQUENCY OF USE

WHEN WAS THE LAST MEDICATION CHANGE MADE?

WOULD THE SIDE EFFECTS FROM THE PRESCRIBED MEDICATIONS INTERFERE WITH YOUR PATIENT'S ABILITY TO DRIVE SAFELY?

Yes  No If yes, please describe:

DOES YOUR PATIENT'S MEDICAL CONDITION CURRENTLY AFFECT SAFE DRIVING?

Yes  No If yes, please explain:

DO YOU CURRENTLY ADVISE AGAINST DRIVING?

Yes  No

WOULD YOU RECOMMEND A DRIVING TEST BE GIVEN BY DMV?

Yes  No

MP COMMENTS:

**8. LEVELS OF FUNCTIONAL IMPAIRMENTS**

Functional impairments that may affect safe driving ability. Please check where applicable.

	MILD	MODERATE	SEVERE
Visual neglect .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Left side <input type="checkbox"/> Right side			
Loss of upper extremity motor control ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Left side <input type="checkbox"/> Right side			
Loss of lower extremity motor control .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Left side <input type="checkbox"/> Right side			

WOULD ADAPTIVE DEVICES AID YOUR PATIENT IN COMPENSATING FOR HIS/HER DISABILITY AS IT PERTAINS TO SAFE DRIVING?

Yes    No    Uncertain

IF YES, PLEASE DESCRIBE

**9. DEMENTIA OR COGNITIVE IMPAIRMENTS**

Alzheimer's Disease

Other Dementia (*Please describe the type of dementia below, e.g., multi-infarct, metabolic, post-traumatic.*)

HISTORY OF DISEASE, RESULTS OF TESTING, ETC.

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Using the definitions given below, please rate the severity of the following forms of cognitive impairments in this patient.

**Mild:** Judgment is relatively intact but work or social activities are significantly impaired. Ability to safely operate a motor vehicle may or may not be impaired.

**Moderate:** Independent living is hazardous and some degree of supervision is necessary. The individual is unable to cope with the environment and driving would be dangerous.

**Severe:** Activities of daily living are so impaired that continual supervision is required. This person is incapable of driving a motor vehicle.

	NONE	MILD	MODERATE	SEVERE	UNCERTAIN
Memory Loss .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression, secondary to dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished Judgment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Attention .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Language Skills .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Visual Spatial Skills .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive Behavior .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem Solving Deficits .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Awareness of Disability .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**OVERALL DEGREE OF IMPAIRMENT**

**10. LAPSE OF CONSCIOUSNESS DISORDER**

PLEASE IDENTIFY THE LAPSE OF CONSCIOUSNESS DISORDER BEING REPORTED (*Type of seizure, nocturnal, isolated, syncope, blackouts, etc.*) DATE(S) OF EPISODE(S) IN THE PAST THREE YEARS

DATE OF ONSET, IF KNOWN

DATE AND TIME OF LAST EPISODE

Please indicate the impairments identified below that are presently shown by your patient.

	YES	NO	UNCERTAIN
Sporadic loss of conscious awareness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired motor function .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EFFECTS AFTER EPISODE**

Confusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished concentration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished judgment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If medication is taken to control seizures, are the serum levels recorded?.....



Are the serum levels medically acceptable?.....



COMMENT \_\_\_\_\_

**11. DIABETES**

PLEASE INDICATE THE TYPE OF DIABETES THIS PATIENT HAS

Type 1    Type 2    Gestational

DATE OF DIAGNOSIS

WHAT METHOD OF TREATMENT IS REQUIRED?

Controlled diet    Oral diabetes medication    Insulin injections    Insulin pump    Other:

HAS THIS PATIENT RECEIVED DIABETES EDUCATION FROM A HEALTH CARE TEAM?

Yes    No

DOES THIS PATIENT COMPLY WITH THE PRESCRIBED TREATMENT PLAN?

Yes    No

IF NO, PLEASE EXPLAIN

IS THE DIABETES MANAGED AT THIS TIME?

Yes    No

IF YES, HOW LONG HAS DIABETES BEEN MANAGED OR MAINTAINED?

IF NO, PLEASE EXPLAIN

WHAT ARE THIS PATIENT'S FASTING BLOOD GLUCOSE LEVELS?

AFTER HOW MANY HOURS OF FASTING?

WITHIN THE LAST THREE YEARS, HAS THIS PATIENT EXPERIENCED

Hypoglycemic episodes?    Hyperglycemic episodes?

REASON FOR EPISODES (e.g., non-compliance w/regimen, change in condition, insulin unavailable, illness, etc.)

Please indicate the complications manifested by the hypoglycemic or hyperglycemic episodes and rate the severity of each.

	NONE	MILD	MODERATE	SEVERE	UNCERTAIN
Abdominal pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive deficits .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemic unawareness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of stamina .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stupor .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual changes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketoacidosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slowed reactions .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or fatigue .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other.....					

DOES THIS PATIENT MANAGE HYPOGLYCEMIC OR HYPERGLYCEMIC EPISODES?

Yes  No If no, please explain:

HAS THIS PATIENT'S DIABETES CAUSED ANY OF THE FOLLOWING CHRONIC COMPLICATIONS?

Visual changes  Kidney disease  Nervous system disease  Vascular disease

PLEASE DESCRIBE THE EXTENT OF THE COMPLICATIONS

HAS THE PATIENT BEEN HOSPITALIZED WITHIN THE LAST THREE YEARS DUE TO DIABETES COMPLICATIONS?

Yes  No If yes, please give dates:

WHAT COMPLICATIONS NECESSITATED HOSPITALIZATION?

HAS AMPUTATION BEEN NECESSARY?

Yes  No

IF YES, PLEASE EXPLAIN

**12. ADDITIONAL COMMENTS BY MEDICAL PROFESSIONAL CONCERNING ANY CONDITION AFFECTING SAFE DRIVING**

**13. MEDICAL PROFESSIONAL'S SIGNATURE**

MP'S SIGNATURE

X

MP'S NAME (PRINTED)

DATE

CLASSIFICATION OR SPECIALTY

MEDICAL LICENSE NUMBER

TELEPHONE NUMBER

(      )