

# DRIVERS PHYSICAL EXAMINATION REPORT

**Name:** (Please Print) \_\_\_\_\_  
Last First Middle

**Address:** \_\_\_\_\_  
Street City State

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**New Certification**

**Re-certification**

## Health History

	Yes No		Yes No		Yes No
Head or spinal injuries		Cardiovascular Disease		Gastrointestinal ulcer	Suffering from any other disease
Seizures, fits, convulsions or fainting		Tuberculosis		Nervous stomach	Psychiatric disorder
Extensive confinement by illness or injury		Kidney disease		Rheumatic fever	Any other nervous disorder
Muscular disease		Diabetes		Permanent defect from illness, disease or injury	

If answer to any of the above is yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

## Physical Examination

**General appearance and development:** Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

**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 or vision:** Right \_\_\_\_\_ Left \_\_\_\_\_

**Hearing:** Right ear: \_\_\_\_\_ Left ear: \_\_\_\_\_

Disease or injury: \_\_\_\_\_

**Audiometric Test:** (complete only if audiometer is used to test hearing)

Decibel loss as 500 Hz \_\_\_\_\_, at 1,000 Hz \_\_\_\_\_, at 2,000 Hz \_\_\_\_\_

**Heart:** \_\_\_\_\_ **Lungs:** \_\_\_\_\_

If organic disease is present, is it fully compensated?

**Blood Pressure:** Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

**Pulse:** Before Exercise \_\_\_\_\_ Regular \_\_\_\_\_ Immediately after Exercise \_\_\_\_\_ Regular \_\_\_\_\_

**Abdomen:**

**Scars:** \_\_\_\_\_

**Abnormal masses:** \_\_\_\_\_ **Tenderness** \_\_\_\_\_

**Hernia:** Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where?

**Reflexes:** Romberg \_\_\_\_\_

**Pupillary Reflex:** Light \_\_\_\_\_ Right: \_\_\_\_\_ Left: \_\_\_\_\_

**Knee Jerks:** Right Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_

Left Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_

**Accommodation:** Right: \_\_\_\_\_ Left: \_\_\_\_\_

**Remarks**

**Extremities:** Upper \_\_\_\_\_ Lower \_\_\_\_\_

Spine: ROM \_\_\_\_\_ Alignment \_\_\_\_\_

**Other laboratory Data** (Serology, etc.) \_\_\_\_\_

**Electrocardiograph** (at Physician's discretion): \_\_\_\_\_

**Radiological Data:**

**General Comments:**

**Name of Examining Doctor:** \_\_\_\_\_  
(PRINT)

**M.D. Signature:** \_\_\_\_\_

**Location:** \_\_\_\_\_  
Address City/State Zip

**Phone:** \_\_\_\_\_ **Date of Examination:** \_\_\_\_\_