DMV Medical Evaluation Form

PATIENT INFORMATION

Name: _____ Address: _____

City: _____ State: _____

ZIP: _____ Date of birth: _____ dd / mm / yyyy

Phone number: _____ Driver's license number: _____

MEDICAL HISTORY (TO BE COMPLETED BY THE DRIVER)

1. Have you been diagnosed with any medical conditions that may affect your ability to safely drive?

◯ Yes ◯ No

If yes, please specify:

2. Do you take any medications that could impair your driving ability?

◯ Yes ◯ No

If yes, list medications:

3. Have you experienced any of the following? (Check all that apply)

- ☐ Vision problems (e.g., blurred vision, double vision)
- ☐ Hearing loss
- ☐ Seizures or fainting
- ☐ Cognitive issues (e.g., memory loss, confusion)
- ☐ Physical limitations (e.g., difficulty turning the wheel, using pedals)

4. Do you use any assistive devices while driving (e.g., glasses, hearing aids, prosthetics)?

◯ Yes ◯ No

If yes, please specify:

MEDICAL EXAMINATION (TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL)

1. Vision assessment

Visual Acuity (corrected) - OD: _____ Visual Acuity (corrected) - OS: _____

Visual Acuity (corrected) - OU: _____

Field of Vision - Specify below:

Does the driver meet the minimum vision requirements to drive?

◯ Yes ◯ No

2. Hearing assessment

Does the driver have adequate hearing to safely operate a vehicle?

◯ Yes ◯ No

Notes:

3. Cognitive and neurological function

Any signs of impairment that may affect safe driving?

◯ Yes ◯ No

Notes:

4. Physical examination

Can the driver perform essential tasks such as turning the wheel, pressing pedals, and checking blind spots?

◯ Yes ◯ No

Notes:

5. Overall assessment

Based on this examination, is the individual medically fit to safely operate a motor vehicle?

◯ Yes ◯ No ◯ With restrictions

Specify restrictions (if applicable):

MEDICAL PROFESSIONAL CERTIFICATION

I certify that I have conducted a medical evaluation of the individual named above, and my findings are true and accurate to the best of my knowledge.

Name: _____ **License number:** _____

Specialty: _____ **Phone:** _____

Date: _____ dd / mm / yyyy

Signature:

FOR DMV USE ONLY

Date received: _____ dd / mm / yyyy Reviewed by: _____

Action taken: