



HEALTH QUESTIONNAIRE

DO NOT use this form for Commercial Licensing Requirements.

The applicant completes this form.

INSTRUCTIONS: Please 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. If you are not sure how to answer a specific question, please contact your physician for assistance. "Yes" answers to any question may require DMV to contact your physician about your medical qualifications before DMV can issue you a license. **You must submit a completed health questionnaire every two years.**

SECTION 1 — PLEASE TELL US ABOUT YOURSELF

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

SECTION 2 — HEALTH QUESTIONS

	YES	NO
1. Do you 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 your side (peripheral) vision less than 70° for either eye?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty perceiving a forced whispered voice in your better ear, with or without a hearing aid, at not less than five (5) feet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a vision impairment in either eye that is not correctable to visual acuity of 20/40 or better?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you:		
a. Have a missing foot, leg, hand, finger or arm?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have any impairment of a hand or finger?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have any other impairment of an arm, foot, leg or any other limitation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have diabetes requiring insulin?	<input type="checkbox"/>	<input type="checkbox"/>
a. Have you had a hypoglycemic episode in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you had any other adverse reaction related to diabetes in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," have you had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," is your respiratory condition likely to interfere with your ability to drive a motor vehicle safely?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," is your blood pressure usually 140/90 or higher?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you 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. Have you 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. Have you been diagnosed with epilepsy or any other condition that may cause lapse of consciousness or loss of control?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," have you had a lapse of consciousness or loss of control in the last three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you use a controlled substance, amphetamine, narcotic, or any other habit-forming drug?	<input type="checkbox"/>	<input type="checkbox"/>
a. If "yes," did your doctor prescribe the drug?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did your doctor advise you NOT to drive when taking the drug?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a current clinical diagnosis of alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>
If "yes," when was your last drink of an alcoholic beverage?		

EXPLAIN ANY "YES" ANSWERS HERE

PHYSICIAN'S NAME (PLEASE PRINT)	DATE OF LAST VISIT
PHYSICIAN'S OFFICE ADDRESS	PHYSICIAN'S PHONE NUMBER ()

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I hereby give consent to the release of medical information by the above named physician.

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