STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

DRIVER MEDICAL EVALUATION

(Medical information is CONFIDENTIAL under *California Vehicle Code* §1808.5 CVC)

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 (DMV) 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:

PHYSICIAN RETURN FORM TO: | RETURN BY:

SECTION 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
	X

SECTION 2 — DRIVER'S ADVISORY STATEMENT

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

All records of the DMV, relating to the physical or mental condition of any person, are confidential and not open to public inspection (CVC §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.

SECTION 3 — MEDICAL INFORMATION AUTHORIZATION

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

DATE	MEDICAL RECORD/PATIENT FILE NO.

I hereby authorize my medical professional or hospital to answer any questions from the DMV, 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 DMV or its employees. Any expense involved is to be charged to me and not to the DMV.

I hereby authorize the DMV 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	DATE
X	

Print | Clear Form

SECTIONS 5 -13 TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE

SECTION 4 — MEDICAL PROFESSIONAL'S MEDICAL EVALUATION INSTRUCTIONS

INSTRUCTIONS TO THE MEDICAL PROFESSIONAL (MP): The DMV 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.

SECTION 5 — VISION

VISUAL ACUITY (without bioptic telescope)	BOTH EYES	RIGHT EYE	LEFT EYE
Without Lenses	20/	20/	20/
With Present Lenses	20/	20/	20/

ANY EYE INJURY OR DISEASE? (LIST)

IS FURTHER EYE EXAMINATION SUGGESTED?
☐ Yes ☐ No

SECTION 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

SECTION 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:

SECTION 8 — LEVELS OF FUNCTIONAL IMPAIRMENTS

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

	MILD	MODERATE	SEVERE
Visual neglect	☐	☐	☐
☐ Left side ☐ Right side			
Loss of upper extremity motor control	☐	☐	☐
☐ Left side ☐ Right side			
Loss of lower extremity motor control	☐	☐	☐
☐ Left side ☐ Right side			

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

☐ Yes ☐ No ☐ Uncertain

IF YES, PLEASE DESCRIBE

SECTION 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.

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	☐	☐	☐	☐	☐
Depression, secondary to dementia	☐	☐	☐	☐	☐
Diminished Judgment	☐	☐	☐	☐	☐
Impaired Attention	☐	☐	☐	☐	☐
Impaired Language Skills	☐	☐	☐	☐	☐
Impaired Visual Spatial Skills	☐	☐	☐	☐	☐
Impulsive Behavior	☐	☐	☐	☐	☐
Problem Solving Deficits	☐	☐	☐	☐	☐
Loss of Awareness of Disability	☐	☐	☐	☐	☐
OVERALL DEGREE OF IMPAIRMENT		☐	☐	☐	

SECTION 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	☐	☐	☐
Loss of consciousness	☐	☐	☐
Impaired motor function	☐	☐	☐

EFFECTS AFTER EPISODE

Confusion	☐	☐	☐
Diminished concentration	☐	☐	☐
Diminished judgment	☐	☐	☐
Memory loss	☐	☐	☐

If medication is taken to control seizures, are the serum levels recorded?	☐	☐
Are the serum levels medically acceptable?	☐	☐

COMMENT _____

SECTION 11 — DIABETES

PLEASE INDICATE THE TYPE OF DIABETES THIS PATIENT HAS	DATE OF DIAGNOSIS
☐ Type I ☐ Type 2 ☐ Gestational	

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	☐	☐	☐	☐	☐
Cognitive deficits	☐	☐	☐	☐	☐
Confusion	☐	☐	☐	☐	☐
Disorientation	☐	☐	☐	☐	☐
Incoordination	☐	☐	☐	☐	☐
Hypoglycemic unawareness	☐	☐	☐	☐	☐
Lack of stamina	☐	☐	☐	☐	☐
Loss of consciousness	☐	☐	☐	☐	☐
Stupor	☐	☐	☐	☐	☐
Visual changes	☐	☐	☐	☐	☐
Ketoacidosis	☐	☐	☐	☐	☐
Slowed reactions	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Weakness or fatigue	☐	☐	☐	☐	☐

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?	WHAT COMPLICATIONS NECESSITATED HOSPITALIZATION?
☐ Yes ☐ No If yes, please give dates:	

HAS AMPUTATION BEEN NECESSARY?

☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

SECTION 12 — ADDITIONAL COMMENTS BY MEDICAL PROFESSIONAL CONCERNING ANY CONDITION AFFECTING SAFE DRIVING

SECTION 13 — MEDICAL PROFESSIONAL'S SIGNATURE

MP'S SIGNATURE	MP'S NAME *(PRINTED)*	DATE
X		
CLASSIFICATION OR SPECIALTY	MEDICAL LICENSE NUMBER	TELEPHONE NUMBER
		( )

Print Clear Form