# DMV Medical Evaluation Form

| Driver information | |
|---|---|
| **Name:** | |
| **Address:** | |
| **City:** | |
| **State:** | **ZIP:** |
| **Date of birth:** | **Phone number:** |
| **Driver's license number:** | |

| Health 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: | OS: | OU: |
| Field of Vision: | | |
| 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:** | **Signature:** |
| **For DMV Use Only** | |
| **Date received:** | **Reviewed by:** |
| **Action taken:** | |