Medical History Exam

DRIVER PERSONAL INFORMATION

Name (Last, First): _____ Physical Date: _____

Age: ____ Height: ____ Weight: ____ Temperature: ____ Blood Pressure: ____ / ____ Pulse: ____ Respirations: ____ Nurse: _____

Current Medications:

Allergies Reaction

- Dentures/Partials ☐
- Frequent Headaches ☐
- Migraine ☐
- Dizziness/Fainting Spells ☐
- Vertigo ☐
- Unconsciousness ☐
- Amnesia ☐
- Color Blind ☐
- Hay Fever ☐
- Sinusitus ☐
- Asthma ☐
- Arthritis ☐
- Diabetes ☐
- Hypoglycemia ☐
- Hepatitis ☐
- History of Heart Disease ☐
- Hypertension ☐
- Anemia or other Blood Diseases inc ABN Bleeding ☐
- Stomach Trouble ☐
- Kidney Trouble ☐
- Kidney Stone ☐
- Blood in Urine ☐
- Sugar or Albumin in Urine ☐
- Epilepsy ☐
- Nervous Trouble ☐
- Mental Illness ☐
- Syphilis ☐
- Smoke ☐
- Smokeless Tobacco ☐
- Drug or Narcotic Habit ☐
- Alcohol Abuse ☐
- Suicide Attempted ☐
- Motion Sick ☐
- Admission to Hospital ☐
- Operations ☐
- Amputation or Physical Disability ☐
- Other Ill ☐
- Tetanus ☐
- Year Tetanus Immunization ____
- MMR ☐
- Year MMR ____
- Pertussis ☐
- Year Pertussis ____
- Rejected for Life Insurance ☐
- Medical Rejection from Military Service ☐
- Military Medical Discharge ☐
- Disability Comp from VA, etc ☐
- Previous Waiver for Medical Defects ☐

Abnormalities Comment(s):

URINALYSIS