



**Health Questionnaire – Driver Wellness & Safety Division**

The Driver Wellness & Safety Division of the Maryland Motor Vehicle Administration has been asked to review your medical status as it relates to driving. A comprehensive medical history is needed for this assessment. Please complete this questionnaire carefully, as instructed below.

**INSTRUCTIONS**

1. Please print all information legibly.
2. Mark the appropriate YES or NO box in the following manner:
3. Use the following format for questions requiring a date: MM / DD / YYYY. For example: 11/26/2000
4. Please answer each question to the best of your ability. Space has been provided on the form for you to write additional information or comments you believe would help us understand your medical condition.
5. All medical information will be kept confidential as in the traditional doctor/patient relationship.

**SECTION A**

DRIVER LICENSE IDENTIFICATION NUMBER ____ - ____ - ____ - ____ - ____ - ____			TODAY'S DATE ____ / ____ / ____
LAST NAME	FIRST	MIDDLE	FORMER
DATE OF BIRTH ____ / ____ / ____	SEX (Circle) M      F	HOW MANY YEARS HAVE YOU HAD A DRIVER'S LICENSE? _____	
REASONS FOR MEDICAL ADVISORY BOARD REVIEW  _____			

**SECTION B**

1. How would you rate your current overall health? (circle one)

Excellent      Good      Fair      Poor

If poor, please comment:

\_\_\_\_\_

\_\_\_\_\_

2. Are you aware of any medical condition that you have that could affect your ability to drive safely?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please comment:

\_\_\_\_\_

## SECTION C

Have you taken any of the following medications regularly in the last 12 months?

YES NO

1.   Medicine for seizures or convulsions
2.   Insulin for diabetes  
Date of your last blood glucose & HbA1C test \_\_\_ / \_\_\_ / \_\_\_  
Test results: Glucose \_\_\_\_\_  
HbA1C tests \_\_\_\_\_
3.   Heart medicine
4.   Medication for narcolepsy
5.   Medication for multiple sclerosis
6.   Medication for Parkinson's Disease
7.   Medication for panic disorder
8.   Medication for alcohol abuse
9.   Medication for drug abuse
10.   Medication for chronic pain
11.   Medication for memory problems
12.   Medication for schizophrenia
13.   Do you require portable oxygen?

14. List names of all medicines taken regularly (at least once a week). Please check labels on containers.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. What major surgical operations have you had?

Condition \_\_\_\_\_

Year \_\_\_\_\_

Condition \_\_\_\_\_

Year \_\_\_\_\_

Condition \_\_\_\_\_

Year \_\_\_\_\_

16. Primary Care Physician \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

## SECTION D

YES NO **Have you ever had**

1.   Temporary loss of vision in either eye
2.   Glaucoma (high pressure in the eye)
3.   Cataracts
4.   Serious eye injury Date \_\_\_ / \_\_\_ / \_\_\_
5.   Eye surgery (including laser surgery)  
\_\_\_ / \_\_\_ / \_\_\_
6.   Blindness in either eye  
Age of onset \_\_\_\_\_
7.   Loss of side (peripheral) vision
8.   **During the past 12 months have you had** Any difficulty seeing in reduced light (night vision)?

YES NO

9.   Have you had a decrease in vision in one or both eyes?
10.   Have you had blurred or double vision?
11.   Have you had trouble estimating distance when driving?
12.   Have you been missing road signs, traffic signals, etc?
13.   Do you have any other eye or vision problem(s) not covered above?  
If yes, please describe \_\_\_\_\_

## SECTION E

YES NO **Have you ever had**

1.   A heart attack? If yes,  
Year(s) \_\_\_\_\_
2.   A stroke or "mini stroke" (TIA)?  
Year(s) \_\_\_\_\_
3.   Do you have  
A heart pacemaker?  
If yes, when was it put in place?  
Date \_\_\_ / \_\_\_ / \_\_\_
4.   A heart defibrillator?  
If yes, when was it put in place?  
Date \_\_\_ / \_\_\_ / \_\_\_

YES NO

5.   Does minimal activity cause you to be short of breath or fatigued?
6.   Do you require treatment for kidney failure (including dialysis)? If yes,  
  Does this condition, or treatment for this condition, affect your driving?

### SECTION E Continued

- YES NO
7.   Are you undergoing radiation or chemo therapy for cancer (malignancy)? If yes,  
  Does this treatment affect your driving?
8.   Have you required treatment for a problem with circulation in your arms or legs? If yes,

- YES NO
- What was the treatment? \_\_\_\_\_  
\_\_\_\_\_
- When was the treatment?  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Does the circulation problem affect your ability to drive?

### SECTION F

- YES NO **Have you ever had (Circle which apply)**
1.   Epilepsy - Convulsions - Seizures - Blackout spells - Fainting spells  
Date last event \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Number of events in the past 12 months \_\_\_\_\_
2.   Have you had any surgical procedure to control seizures? Examples, brain surgery (including external laser treatment), implantation of vagal nerve stimulator  
What was the procedure? \_\_\_\_\_  
When was it performed?  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_

- YES NO
3.   A head injury resulting in unconsciousness?  
Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_
4.   If you have diabetes, have you had a loss of consciousness, or required assistance due to a low blood sugar in the past year?  
When \_\_\_\_ / \_\_\_\_ / \_\_\_\_
5.   Have you been diagnosed with sleep apnea?
6.   Have you been diagnosed with narcolepsy?
7.   In the past year, have you had any significant changes in your ability to remember things?
8.   In the past year, have you gotten lost while driving?

### SECTION G

- YES NO
1.   Do you have difficulty turning your head from side to side?
2.   Do you have problems with shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?  
  Does it affect your ability to drive?
3.   Have you been diagnosed with any condition or disease that causes shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?  
If yes, what is the condition? \_\_\_\_\_  
\_\_\_\_\_  
When was it diagnosed?  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Does it affect your ability to drive?
4.   Do you require any of the following to get around? (Circle those that apply)  
-Cane/Crutch -Walker -Wheelchair  
-Scooter

- YES NO
5.   Have you had an extremity or part of an extremity [arm/hand/finger(s): leg/foot toe(s)] amputated, or do you have any extremities that are not fully developed?  
If yes, which extremity or part of an extremity? \_\_\_\_\_  
Is this condition the result of (please check)  
\_\_\_\_\_ amputation or  
\_\_\_\_\_ development?  
If an amputation, when was it performed? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
6.   Have you had a fall in the past three years?
7.   Do you have any difficulty keeping your balance?
8.   Do you have any difficulty walking?

