Tennessee Department of Safety
Driver Improvement Section
P.O. Box 945
Nashville TN 37202

MEDICAL REPORT

I hereby authorize Dr.____________________________ to give me any examination he deems necessary for the purpose of determining my fitness to operate a motor vehicle. I also authorize the Department of Safety to have this information reviewed by a consulting board of unidentified physicians for the purpose of giving the department a medical evaluation on my case. I understand that the department is in no way responsible for any expense that arises from this examination.

____
Signature of patient Date

This report must be completed by a licensed physician, in addition to any hospital, medical or VA records that you wish to make part of your medical history with this department. This examination must have been performed within the twelve (12) months.

Name ____ Date of Birth______________________________

Address____ Case Number_____________________________

____ Driver License#___________________________

Patients Medical History

(PLEASE TYPE OR PRINT LEGIBLY)

Does the patient have any physical or mental impairments? Yes____ No_____ If yes, explain___________
____

Does the patient use any drugs/medicine regularly? Yes_____ No_____. If yes, explain___________________
____

To your knowledge is medication taken as prescribed? Yes_____ No_____. If no, explain________________
____

Does Patient drink alcoholic beverages? Yes____ No____. If yes, to what extent?________________________

What effect would alcohol and patient's medication have on patient?____________________________________

Is there any parkinson's disease? Yes____ No____. Is coordination normal? Yes____ No____. Is there any vertigo? Yes____ No____. Is there any disease present which would effect the nervous system and/or the motor senses (coordination)? Yes____ No____. If yes, explain____

Is this condition being treated? Yes____ No____. If yes, explain ______________________________________

List names of physicians with their field of medicine that have treated this patient in the last two years.

Physicians name	Field of medicine
___________________________________	___________________________
___________________________________	___________________________

CARDIAC Functional Capacity (AHA)

Class 1 No limitation physical activity ______________________________
Class 2 Slight limitation physical activity ______________________________
Class 3 Marked limitation physical activity ______________________________
Class 4 Complete limitation physical activity ______________________________

Blood pressure________________________ Edema ______________________________
Dyspnea and/or Angina: At rest ______________________________
Slight exertion ______________________________
Moderate ______________________________
Is There any syncope? _________________ If Yes, frequency and severity ______________________
Does the patient take Nitroglycerin or blood pressure medicine? Yes____ No____. If yes, daily dosage?
____

DIABETIC Yes _____ No _____ If yes, please complete questions below.

Age of onset ____________ Does patient take insulin? Yes _____ No _____. If Yes how much? ______________

What type of insulin is taken? ____________________________________.

Has patient ever been in coma? ______ How Many times? ________________ Date of last coma _________________.

Has patient ever had insulin shock? Yes _____ No _____ How many times? _________________________

Date of last insulin shock? _________________. Is there any warning of impending coma or shock? __________

Urine Analysis ____ S.P.G.R. ________________________________

Albumin _____________________ Sugar ____________________________ Micro___________________________

ORTHOPEDIC Yes ________ No _________ If yes, please complete questions below.

Are there any stiff or flail joints? Yes _____ No _____. If yes, where? ___________________________________

Have there been any amputations? Yes _____ No _____. If yes, where?____________________________________

Are there any spastic or paralyzed muscles? Yes____ No____. If yes, where? ____________________________

Does patient need orthopedic appliances or supports? Yes____ No____ If yes, where?______________________

Do any of the above interfere with the patient's driving? Yes____ No____. If yes, to what extent? ____________
____.

HEARING Conversational voice-distance in feet __________ Audiometric test if indicated______________

Is hearing aid worn? Yes_____ No_____. If yes, does it give sufficient correction? Yes_____ NO______.

VISUAL Visual acuity- Name type of equipment used ____

Without Glasses RE 20/______________ LE 20/__________________ BE 20/_____________________________

With glasses RE 20/______________ LE 20/__________________ BE 20/_____________________________

Field of vision _______________________________ Color vision_______________________________________

Coordination ________________________________ Depth perception___________________________________

IF ANY OF THE FOLLOWING APPLIES TO PATIENT, HE/SHE MUST HAVE THEIR PERSONAL EYE DOCTOR COMPLETE THIS PORTION OF THE MEDICAL REPORT.

Is there any disease that would contribute to the loss of sight or impair the patient's ability to operate a motor vehicle? (cataracts, glaucoma, etc.)________________________________ Has this condition been treated by surgery Yes_____ No_____. If yes, what were the results____

Is there any retina detachment, etc. present at this time? Yes_____ No_____ If Yes explain_________________

Is patient diabetic? Yes_____ No______ If yes, what effect does it have on the eyes. If any_________________

____.

What is the best possible vision if any of the above applies? RE20/_______ LE20/_______ BE20/_______

PSYCHOLOGY (To be completed by psychologist, if applies)

What was the highest grade completed in school? _________ At what age was it obtained? ______________

Has patient ever been institutionalized or treated in a hospital for mental illness? Yes_____ No_____. If yes, when ________________________ History ____.

Was patient restored to competency? Yes_____ No_____ If yes, by what authority?_______________________

Is patient on medication? Yes_____ No_____ If yes, what kind?_______________________________________

Dosage?_____________________________. What effect, if any does the medication have on patients ability to operate a motor vehicle?____

Has patient ever been committed to a hospital for alcohol or drug treatment? Yes_____ No______. If yes, explain ____ Dates______________________________

Location________________________________ How many times?_______ Length of stay_________________

What type of discharge did patient receive?_______________________________________ Was medication prescribed at time of release? Yes_____ No_____ If yes, what kind of medication_________________________

____ Dosage_______________________________________

To your knowledge has patient used drugs or alcohol in excess since his release from the hosptial?___________

In your opinion should this person be permitted to drive? Yes_____ No_____ If no, please explain___________

____

PLEASE LIST OTHER SIGNIFICANT FINDINGS WHICH IN YOUR OPINION WOULD INHIBIT THE INDIVIDUAL'S ABILITY TO OPERATE A MOTOR VEHICLE SAFELY. ____________________________

____

____

____

NEUROLOGICAL

Has this patient ever had a seizure? Yes_______ No_______.   Loss of consciousness? Yes_______ No_______

If yes to the above give dates_________________________ If yes to the above give dates_________________

What caused seizure or loss of consciousness?____

Age of first seizure?_______ Type(s) Major motor_____ Minor Lapses_____ Other_____________________

Describe____

Have any spells occurred when patient is awake? Yes_____ No______ Medication patient was taking at the

time of last seizure____

Date of last seizure________________________________ Medication patient is presently________________

______________________________ Do you think the patient takes medication regularly? Yes_____ No_____

When did you last check patient's serum anticonvulsant levels?_______________________________________

How long have you treated this patient for this condition?____

EXAMINING PHYSICIAN

How long you have you treated this patient?____________________________

Date you last examined or treated this patient?__________________________

Date questionnaire completed?_______________________________________

NOTE: The Department of Safety requires, before an individuals driving privileges be reinstated, a six-month period of time lapse without the occurrence of the following conditions: Seizure, blackout, insulin shock, coma or any condition whereas control of physical motor movements are lost.

FOR THIS MEDICAL REPORT TO BE CONSIDERED, THE NEXT QUESTION MUST BE ANSWERED AND REPORT SIGNED BY A LICENSED PHYSICIAN.

IN YOUR PROFESSIONAL OPINION IS THIS PATIENT MEDICALLY AND MENTALLY CAPABLE OF

OPERATING A MOTOR VEHICLE SAFELY? YES__________ NO_________

____

NAME OF PHYSICIAN (PLEASE PRINT) DATE I.D. NUMBER

____

SIGNATURE OF PHYSICIAN PHONE NUMBER

____

ADDRESS CITY STATE ZIP

The Department of Safety is in no way responsible for any expenses that may result from this examination.