DOT ePhysical Form

Today's Date: ______________________________

Name: First: ______________________________ Middle: ________________ Last: ________________________

SSN: _____________________________________ Date of Birth: ____

Daytime Phone: ____________________________ Evening Phone: _______________________________________

Select the ID that applies to today's visit: ☐ Driver's License ☐ Passport ☐ Employee ID ☐ Health ID ☐ Military ID ☐ Other: _____________________

ID Number: _________________________________ **Issuing State:** ____

Gender: ☐ Male ☐ Female **Reason for Visit:** ☐ New Certification ☐ Recertification

Street Address: ____

City: _____________________________________ **State:** __________________ **Zip:** _________________________

Email Address (optional): ____

Is this a Commercial License? ☐ Yes ☐ No **Is this a Commercial Learner's Permit?** ☐ Yes ☐ No

Has your USDOT\FMCSA medical certificate ever been denied or issued for less than 2 years? ☐ Yes ☐ No

A Medical Review Board may need to contact you directly to review your answers. (REQUIRED) Contact me via:

☐ **SMS/Automated Phone (Automated Message)** ☐ **Manual Phone (Live Person)**

DRIVER HEALTH HISTORY - Please complete the following questions.
Comment on any "Yes" or "Not Sure" answers in the space provided below.

Yes No Not Sure

☐ ☐ ☐ Have you ever had a surgery?

☐ ☐ ☐ Are you currently taking medication (prescription, over-the-counter, herbal remedies, diet supplements)?

☐ ☐ ☐ 1. Head\brain injuries or illness (e.g. concussion):

- ☐ Concussion
- ☐ Traumatic Brain Injury
- ☐ Brain Disorder
- ☐ Brain Tumor
- ☐ Brain Surgery
- ☐ Brain Aneurysm

☐ ☐ ☐ 2. Seizures or epilepsy:

- ☐ History of a Seizure (single episode)
- ☐ Seizure Disorder

Yes No Not Sure

☐ ☐ ☐ 3. Eye problem (except glasses or contacts):

- ☐ Vision Problems
- ☐ Glaucoma
- ☐ Macular Degeneration

☐ ☐ ☐ 4. Ear and\or hearing problems:

- ☐ Ear Disorder
- ☐ Hearing Loss, left ear
- ☐ Hearing loss, right ear
- ☐ Hearing loss, both ears
- ☐ Meniere's disease

Yes No Not Sure

☐ ☐ ☐ 5. Heart disease, heart attack, bypass or other heart procedures:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Cardiac Bypass
- ☐ Cardiac Arrhythmias
- ☐ Other Heart Disorder

☐ ☐ ☐ 6. Pacemaker, stents, implantable devices or other heart procedures:

- ☐ Cardiac Pacemaker
- ☐ Implantable Defibrillator
- ☐ Cardiac Stent Placement
- ☐ Heart Valve Replacement
- ☐ Cardiac Catheterization
- ☐ Cardiac Balloon Angioplasty
- ☐ Cardiac Ablation

☐ ☐ ☐ 7. High blood pressure.

☐ ☐ ☐ 8. High cholesterol.

☐ ☐ ☐ 9. Chronic (long-term) cough, shortness of breath or other breathing problems:

- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Breathing problems

☐ ☐ ☐ 10. Lung disease (e.g. asthma):

- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis

☐ ☐ ☐ 11. Kidney problems, kidney stones or pain\problems with urination:

- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Other Kidney Problems

Yes No Not Sure

☐ ☐ ☐ 12. Stomach, liver or digestive problems:

- ☐ Stomach problem
- ☐ Liver problem
- ☐ Digestive Problem

☐ ☐ ☐ 13. Diabetes or blood sugar problems.

Insulin used? ☐ No ☐ Yes, name________________

☐ ☐ ☐ 14. Anxiety, depression, nervousness or other mental health problems:

- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Mental Health Problems

☐ ☐ ☐ 15. Fainting or passing out.

☐ ☐ ☐ 16. Dizziness, headaches, numbness, tingling or memory loss:

- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Memory Loss

☐ ☐ ☐ 17. Unexplained weight loss.

☐ ☐ ☐ 18. Stroke, mini-stroke (TIA), paralysis or weakness:

- ☐ Mini-stroke (TIA)
- ☐ Stroke
- ☐ Paralysis
- ☐ Muscle Weakness

☐ ☐ ☐ 19. Missing or limited use of arm, hand, finger, leg, foot or toe:

- ☐ Amputation of arm
- ☐ Amputation of hand
- ☐ Amputation of finger
- ☐ Amputation of leg
- ☐ Amputation of foot
- ☐ Amputation of toe
- ☐ Incomplete paralysis

Yes No Not Sure

☐ ☐ ☐ 20. Neck or back problems:
- ☐ Neck problem
- ☐ Back problem
- ☐ Spine Surgery

☐ ☐ ☐ 21. Bone, muscle, joint or nerve problems:
- ☐ Bone Disorder
- ☐ Muscle Disorder
- ☐ Joint Disorder
- ☐ Nerve Disorder

☐ ☐ ☐ 22. Blood clots or bleeding problems:
- ☐ History of Blood Clots
- ☐ Bleeding Disorder
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Pulmonary Embolism

☐ ☐ ☐ 23. Cancer.

☐ ☐ ☐ 24. Chronic (long-term) infection or other chronic diseases:
- ☐ Chronic Infection
- ☐ Chronic Disease

☐ ☐ ☐ 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring:
- ☐ Sleep apnea on CPAP machine
- ☐ Sleep apnea not currently on CPAP machine
- ☐ Sleep disorder breathing
- ☐ Daytime sleepiness
- ☐ Loud snoring

Yes No Not Sure

☐ ☐ ☐ 26. Have you ever had a sleep test (e.g. sleep apnea)?

☐ ☐ ☐ 27. Have you ever spent a night in the hospital?

☐ ☐ ☐ 28. Have you ever had a broken bone?

☐ ☐ ☐ 29. Have you ever used or do you now use tobacco?

☐ ☐ ☐ 30. Do you currently drink alcohol?
- ☐ Diagnosis of alcoholism

☐ ☐ ☐ 31. Have you used an illegal substance within the past two years?
- ☐ Marijuana
- ☐ Other

☐ ☐ ☐ 32. Have you ever failed a drug test or been dependent on an illegal substance?

Other Health Conditions not listed:

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Please comment below for any "Yes" or "Not Sure" answers.
Must write NAME of any medications.

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