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

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).

☐ ☐ ☐ 2. Seizures or epilepsy.

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

☐ ☐ ☐ 4. Ear and\or hearing problems.

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

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

☐ ☐ ☐ 7. High blood pressure.

☐ ☐ ☐ 8. High cholesterol.

Yes No Not Sure

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

☐ ☐ ☐ 10. Lung disease (e.g. asthma).

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

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

☐ ☐ ☐ 13. Diabetes or blood sugar problems. Insulin used? _____

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

☐ ☐ ☐ 15. Fainting or passing out.

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

☐ ☐ ☐ 17. Unexplained weight loss.

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

Yes No Not Sure

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

☐ ☐ ☐ 20. Neck or back problems.

☐ ☐ ☐ 21. Bone, muscle, joint or nerve problems.

☐ ☐ ☐ 22. Blood clots or bleeding problems.

☐ ☐ ☐ 23. Cancer.

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

☐ ☐ ☐ 25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring.

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

Yes No Not Sure

☐ ☐ ☐ 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?

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

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

Other Health Conditions not listed:

_____

_____

_____

Please comment below for any “Yes” or “Not Sure” answers.

_____

_____

_____

_____

_____

_____

_____

_____