Florida Department of Highway Safety and Motor Vehicle

MEDICAL REPORT

Please complete the history and other sections as appropriate. This report must be current and should be completed by your personal physician. Any incomplete or illegible information may delay the review of this case.

NAME: _____ DATE OF BIRTH: _____ DATE: _____

DRIVER LICENSE #: _____ TELEPHONE #: _____

HISTORY

1. List all serious illnesses or physical impairments the patient has had: _____
2. List all prescribed medications: _____
3. Does the patient now receive any disability benefits? _____ Nature of disability? _____
4. How long have you known this patient? _____ Date of last office visit? _____
5. Education level of patient? _____ Other physicians patient has seen in past 2 years? _____

COMPLETE ALL OF THE FOLLOWING SECTIONS THAT APPLY

A. NEUROLOGICAL:

- Does patient have history of blackouts or fainting spells? _____ Frequency? _____
  Possible cause? _____ Date of last one? _____
- Does patient have history of epilepsy or convulsive seizures? _____ Date of last seizure of any type? _____
  Medication and dosage taken for prevention? _____ Current anticonvulsant blood level _____ Date taken _____
  EEG? _____ (please attach copy)
  Is patient reliable in taking medications? _____ Does patient receive regular medical care? _____
  If not within therapeutic range, please explain. _____
  If medication discontinued, give date _____
- Please list any progressive neurological disease: _____
- Please describe any physical activity limitations imposed by condition: _____
  Please list any neurological deficits due to CVA's, closed head injury, etc: _____
- Describe frequency and severity of any vertigo, dizziness, narcolepsy or sleep disorders: _____

B. MENTAL/COGNITIVE:

Is patient's memory normal? _____ Any evidence of organic brain syndrome? _____

Any history of frequent or intermittent confusion? _____

Has patient ever been admitted to a hospital or treated for mental or emotional illness? _____

Date of admission? _____ Discharge? _____ Facility? _____

Is patient presently under treatment for, show evidence of, or have difficulty with any emotional problems or mental illness? _____

If yes, please attach a psychiatric report.

C. ALCOHOL AND DRUG:

Is there any evidence or personal knowledge of addiction, habituation, or abuse of alcohol or other drugs? _____

When and where has patient been treated for alcoholism or drug dependency? _____

Does the patient consume either substance at this time? _____ To what extent? _____

How long has the patient been alcohol and/or drug free? _____

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MEDICAL REPORT (continued)

NAME: _____ DATE OF BIRTH: _____ DATE: _____

DRIVER LICENSE #: _____ TELEPHONE #: _____

D. DIABETES:

What medication is patient taking? _____

How many times has patient been in diabetic ketoacidosis? _____ Date of last episode? _____

Frequency of hypoglycemic episodes involving LOC or near LOC? _____ Date of last episode? _____

The physician's assessment of the control of patient's diabetes? _____

How frequently have you seen this patient for control of control of patient's diabetes? _____

E. CARDIAC:

Please describe any cardiac problem patient has that could interfere with driving? _____

_____

Please provide date of last episode of any LOC related to cardiac abnormalities or arrhythmias? _____

Treatment _____

F. ORTHOPEDIC:

Explain any limitation of motion, weakness, spasticity, or paralysis: _____

_____

Do any of the above interfere with patient's driving? _____

G. VISUAL:

Visual acuity – Name of equipment used _____

Without glasses: RE 20/_____ LE 20/_____ BE 20/_____

With glasses: RE 20/_____ LE 20/_____ BE 20/_____

Field of vision: RE _____ LE _____ BE _____

Dear Doctor: Florida's Medical Advisory Board* is charged with determining the individual's physical and mental qualifications for safe driving ability. The information provided by you is most important in making this determination. In addition, we would like you to provide your opinion below as to whether or not this individual can operate a motor vehicle safely. This will be taken into consideration when rendering a decision in this case.

PLEASE ANSWER "YES" OR "NO" HERE: _____ IF "NO", PLEASE EXPLAIN: _____

_____

_____

Signature of Physician _____ Date _____

Name of Physician – PRINT IN FULL _____

Physician's Address _____

Telephone _____

*Florida's Medical Advisory Board is appointed by the Governor and Cabinet, and consists of members of the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Optometric Association, and the Florida Chiropractic Association.

WHEN THIS FORM IS COMPLETED, please mail directly to:
TELEPHONE NO. (850) 617-3814
HSMV 72423 (Rev.6/11)

BUREAU OF MOTORIST COMPLIANCE
MEDICAL REVIEW SECTION, MS 86
NEIL KIRKMAN BUILDING
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