Medical Examination Report Form
for Idaho Driver Education Instructors

Section 1. Driver Information (to be filled out by the driver) Examination Date:_____

PERSONAL INFORMATION

Last Name:_____ First Name: _____ Middle Initial _____
Date of Birth: _____ Age: _____
Street Address: _____ City: _____ State: _____
Zip code: _____ Driver's License Number: _____ Issuing State: _____
Home/Cell Phone _____ Work Phone _____
Email: _____

DRIVER HEALTH HISTORY

Are you currently taking any medications? ◯ Yes ◯ No

Medication	Dosage	Times per day

Have you ever had surgery? ◯ Yes ◯ No

Type of Surgery	Month/Year

Do you have or have you ever had:	Y	N		Y	N
Head/brain injury or illness			Dizziness, headaches, numbness, or memory loss		
Seizures, Epilepsy			Unexplained weight loss		
Eye problems			Stroke, paralysis, or weakness		
Heart disease, heart attack, bypass			Missing or limited use of arm, hand, leg, or foot		
Pacemaker, stents, implantable devices			Neck or back problems		
Lung disease			Bone, muscle, joint, or nerve problems		
Kidney problems			Blood clots or bleeding problems		
Stomach, liver, or digestive problems			Cancer		
Diabetes or blood sugar problems			Chronic infection or other chronic diseases		
Anxiety, depression, other mental health problems			Sleep disorders		
Fainting or passing out			Dependent on an illegal substance		

Last Name:_____ First Name: _____ DOB:_____ Exam Date:_____

Section 2. Medical Information (to be filled out by the physician)

TESTING

Pulse rate: _____
Blood Pressure: _____/_____
Urinalysis: _____ Sp. Gr
_____ Protein
_____Blood
_____Sugar

Height: ____feet ____inches
Weight: _____ pounds

Vision:	Acuity	Horizontal Field of Vision
Right Eye:	20/____	Right Eye: _____degrees
Left Eye:	20/____	Left Eye: _____degrees
Both Eyes:	20/____	

PHYSICAL EXAMINATION

Body System	Normal	Abnormal	Body System	Normal	Abnormal
General			Abdomen		
Skin			Urinary Analysis		
Eyes			Back/Spine		
Ears			Extremities/Joints		
Mouth/Throat			Neurological system including reflexes		
Cardiovascular			Gait		
Lungs/Chest			Vascular System		

MEDICAL EXAMINER PHYSICAL REPORT

○ Meets medical physical standard of two years.
○ Meets standard, but periodic monitoring required (specify reason):_____
Must return for required monitoring every: ○ 3 months ○ 6 months ○ 1 year

Medical Examiner's Signature: _____ Date:_____

○ MD ○ DO ○ Physician Assistant ○ Advanced Practice Nurse ○ Other (specify)_____

Medical Examiner's Name (please print): _____

Medical Examiner's Address: _____ City: _____ State: ___ Zip: _____