Medical Examination Form

Driver Education

Public driver education and training instructors shall have a medical examination performed by a certified medical professional (3.5.1). The medical examination report must indicate whether the applicant has any ailment, disease, or physical or mental disabilities that may cause momentary or prolonged lapses of consciousness or control, which is or may become chronic. Applicants must not be suffering from a physical or mental disability or disease that may prevent the applicant from maintaining reasonable and ordinary control over a motor vehicle or that could impair the applicant's ability to drive safely or instruct automobile drivers (3.5.3). The medical examination must be renewed upon expiration and a copy of the official form sent of the Idaho Department of Education (3.5.4).

DRIVER INFORMATION

First Name		**Address**	
Last Name		**City**	
Middle Initial		**State**	
Date of Birth		**Zip Code**	
Driver License Number		**Phone**	
Issuing State		**Email**	

HEALTH HISTORY

Medications

Medication	Dosage

Surgery

Type of Surgery	Date

Do you or have you ever had:

Condition	Yes	No	Not Sure
Head/brain injuries or illnesses (e.g., concussion)			
Seizures, epilepsy			
Eye problems (except glasses or contacts)			
Ear and/or hearing problems			
Heart disease, heart attack, bypass, or other heart problems			

Condition	Yes	No	Not Sure
Pacemaker, stents, implantable devices, or other heart procedures			
High blood pressure			
High cholesterol			
Chronic (long-term) cough, shortness of breath, or other breathing problems			
Lung disease			
Kidney problems, kidney stones, or pain/problems with urination			
Stomach, liver, or digestive problems			
Diabetes or blood sugar problems			
Anxiety, depression, other mental health problems			
Fainting or passing out			
Dizziness, headaches, numbness, or memory loss			
Unexplained weight loss			
Stroke, mini-stroke (TIA), paralysis, or weakness			
Missing or limited use of arm, hand, finger, leg, foot, toe			
Neck or back problems			
Bone, muscle, joint, or nerve problems			
Blood clots or bleeding problems			
Cancer			
Chronic (long-term) infection or other chronic diseases			
Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring			
Have you ever had a sleep test (e.g., sleep apnea)			
Have you ever spent a night in the hospital			
Have you ever had a broken bone			
Have you ever used or do you now use tobacco			
Do you currently drink alcohol			
Have you used an illegal substance within the past two years			
Have you ever failed a drug test or been dependent on an illegal substance			

TESTING

Height	
Weight	
Pulse Rate	
Blood Pressure	
Urinalysis	
a. Sp. Gr.	
b. Protein	
c. Blood	
d. Sugar	
Vision Acuity	
a. Right eye	
b. Left eye	
c. Both eyes	
Horizontal Field of vision	
a. Right eye	
b. Left eye	

PHYSICAL EXAM

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

MEDICAL EXAMINATION REPORT

Please only submit this page.

Patient Name	
Date of Birth	
Date of Exam	

Approval

Meets standards in IDAPA 08.02.02.004; qualifies for a 2-year certificate	
Meets standards, but periodic monitoring required	
a. Specify Reason	
b. Duration	
Does not meet standards	
a. Specify Reason	
Expiration	

Medical Examiner Information

A certified medical professional must carry out the medical examination. By completing this section, the medical examiner is verifying the physical and form have been completed by them.

Name		Address	
Title		City	
a. MD		State	
b. DO		Zip	
c. Physician Assistant		Phone Number	
d. Advance Practice Nurse		Signature	
e. Other		Date	