Driving Solutions
Helping you make the right decision

Do you have, or have you had, any of the following in the last five years? Please circle or underline all that apply on this Medical History Questionnaire

---

Diabetes or Other Metabolic Conditions, High blood pressure, use of insulin, fainting , loss of consciousness, low blood sugar, Syncope, Thyroid condition

Cardiovascular: Heart attack, Heart blockage, Heart surgery, Irregular rhythm, Pacemaker, use of statin drugs, falls

Pulmonary: Lung condition, Asthma, Emphysema, Obstructive pulmonary condition, shortness of breath, use of inhaler

Neurologic: Stroke, Epilepsy, Seizure, Multiple sclerosis, ALS, Parkinson's Disease, Brain injury, peripheral neuropathy, concussion, car crash with personal injury or property damage. Narcolepsy. Have you ever fallen asleep while driving? Yes No

Epilepsy: Seizure, other episodic conditions that include any recurrent loss of consciousness or control ? Have you ever had a seizure in your life? Yes No

Learning and Memory: Learning disability, short term memory loss reported by others, difficulty in handwriting or completing school , job or home management tasks. ADD or ADHD sleep apnea treated with medication. Aspbergers, PDD or autism

Psychiatric: Condition of anxiety, stress, depression, bipolar disorder, schizophrenia for which you take medication or have received counseling or hospitalization.

Alcohol and/or Drugs: Dependency or abuse of substances that are known to impair thinking and judgment. Any detox or treatment programs for alcohol or drug dependency. Do you take several prescription medications on a daily basis? Yes No

Visual Problems: Need for reading glasses, need for distance glasses/contact lenses, glaucoma, cataracts, macular degeneration, retinopathy, iritis, legal blindness, loss of vision in part of the visual field, diminished side vision. Do you use daily eye drops? Yes No

Musculosketletal Conditions: Amputation or paralysis of a limb. Arthritis of the neck, spine, low back, knees, ankles, feet, hips. Osteoporosis or congenital abnormalities. Unusually short/long limbs. Any chronic infection or virus that could endanger someone coming in close contact with you? Do you use prescription pain relievers? Yes No

Functional Motor Impairment: Use of a brace, prosthesis, splint, cast, cane or support for any body part. Have you ever had a problem identified with coordination, muscle strength, range of motion or spinal movement that could affect your ability to safely drive? Yes No

Other: List any other conditions or medications that might interfere with safe driving:

Gather Documents:

Please provide a **signed MD order** for OT Driver Evaluation.

Please provide a **list of medications** you currently take.

Please provide a photocopy of your **driver's license** or learner's permit.