Driving Solutions
Helping you make the right decision

Have you had any of the following in the recent past?
Please circle or underline all that apply

Medical History Questionnaire

Diabetes or Other metabolic condition, use of insulin, fainting, low blood sugar

Cardiovascular: Heart attack, Congestive Heart failure, Irregular rhythm, Pacemaker, poor circulation

Falls: Dates_____

Pulmonary: Lung condition, Asthma, Emphysema, COPD, pulmonary embolism, shortness of breath, use of inhaler, sleep apnea

Neurologic: Stroke/TIA, Multiple sclerosis, ALS, Parkinson's, Brain injury, neuropathy, concussion. Narcolepsy. Have you fallen asleep while driving?

Epilepsy/Seizure: other condition that includes recurrent loss of consciousness or control ? Dates_____

Learning and Memory: forgetfulness, learning disability, memory loss reported by others, difficulty in handwriting, ADD/ADHD

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

Alcohol and/or Drugs: Do you drink on a regular basis? Do you use marijuana? Do you take prescription medications on a daily basis?

Visual Problems: Need for glasses/contact lenses, glaucoma, cataracts, macular degeneration, retinopathy, iritis, loss of vision in part of the visual field, diminished side vision. Do you use daily eye drops?

Musculoskeletal conditions: Amputation or paralysis. Arthritis of the neck, spine, back, knees, ankles, feet, hips. Osteoporosis. Unusually short/long limbs? Do you use prescription pain relievers?

Functional Motor Impairment: Use of a brace, prosthesis, splint, cast, cane or support for any body part.

Other: Any other condition or medication that might interfere with safe driving?

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1. Please provide a **signed MD order** for OT Driver Evaluation
2. Please provide a **list of medications** you currently take
3. Provide a copy of your **driver's license** or learner's permit