Motor Vehicle Administration
6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

Driver Wellness & Safety Division Health Questionnaire

The Driver Wellness & Safety Division of the Maryland Motor Vehicle Administration has been asked to review your medical status as it relates to driving. A comprehensive medical history is needed for this assessment. Please complete this questionnaire carefully, as instructed below.

INSTRUCTIONS

1. Please print all information legibly.
2. Mark the appropriate YES or NO box in the following manner: [X]
3. Use the following format for questions requiring a date: MM / DD / YYYY. For example: 11/26/2000
4. Please answer each question to the best of your ability. Space has been provided on the form for you to write additional information or comments you believe would help us understand your medical condition.
5. All medical information will be kept confidential as in the traditional doctor/patient relationship.

SECTION A

DRIVER LICENSE IDENTIFICATION NUMBER			TODAY'S DATE
____-____ ____ ____-____ ____ ____-____ ____ ____-____ ____ ____			_______ / ________ / ________
LAST NAME	FIRST	MIDDLE	FORMER
DATE OF BIRTH _______ / ________ / ________	SEX (Circle) M F	HOW MANY YEARS HAVE YOU HAD A DRIVER'S LICENSE? _________	
REASONS FOR MEDICAL ADVISORY BOARD REVIEW			

SECTION B

1. How would you rate your current overall health? (circle one)

   Excellent Good Fair Poor

   If poor, please comment:

   ____

   ____

2. Are you aware of any medical condition that you have that could affect your ability to drive safely?

   Yes ________ No ________

   If yes, please comment:____

   ____

SECTION C

Have you taken any of the following medications regularly in the last 12 months?

YES NO

1. ❑ ❑ Medicine for seizures or convulsions
2. ❑ ❑ Insulin for diabetes
   Date of your last blood glucose & HbA1C test ___ / ___ / ___
   Test results: Glucose ______
   HbA1C tests _____
3. ❑ ❑ Heart medicine
4. ❑ ❑ Medication for narcolepsy
5. ❑ ❑ Medication for multiple sclerosis
6. ❑ ❑ Medication for Parkinson's Disease
7. ❑ ❑ Medication for panic disorder
8. ❑ ❑ Medication for alcohol abuse
9. ❑ ❑ Medication for drug abuse
10. ❑ ❑ Medication for chronic pain
11. ❑ ❑ Medication for memory problems
12. ❑ ❑ Medication for schizophrenia
13. ❑ ❑ Do you require portable oxygen?

14. *List names of <u>all</u> medicines taken regularly (at least once a week). Please check labels on containers.*
    ____
    ____
    ____
    ____
    ____
    ____
15. What major surgical operations have you had?
    Condition______________________________________
    Year ____
    Condition______________________________________
    Year ____
    Condition______________________________________
    Year ____
16. Primary Care Physician ________________________
    Phone Number (_____) _________________________

SECTION D

YES NO **Have you <u>ever</u> had**

1. ❑ ❑ Temporary loss of vision in either eye
2. ❑ ❑ Glaucoma (high pressure in the eye)
3. ❑ ❑ Cataracts
4. ❑ ❑ Serious eye injury Date ___ / ___ / ___
5. ❑ ❑ Eye surgery (including laser surgery)
   ___ / ___ / ___
6. ❑ ❑ Blindness in either eye
   Age of onset ________________________
7. ❑ ❑ Loss of side (peripheral) vision

During the <u>past 12 months</u> have you had

8. ❑ ❑ Any difficulty seeing in reduced light (night vision)?

YES NO

9. ❑ ❑ Have you had a decrease in vision in one or both eyes?
10. ❑ ❑ Have you had blurred or double vision?
11. ❑ ❑ Have you had trouble estimating distance when driving?
12. ❑ ❑ Have you been missing road signs, traffic signals, etc?
13. ❑ ❑ Do you have any other eye or vision problem(s) not covered above?
    If yes, please describe_________________
    ____

SECTION E

YES NO **Have you <u>ever</u> had**

1. ❑ ❑ A heart attack? If yes,
   Year(s)______________________________
2. ❑ ❑ A stroke or "mini stroke" (TIA)?
   Year(s)______________________________
3. ❑ ❑ Do you have
   A heart pacemaker?
   If yes, when was it put in place?
   Date ____ / ____ / ____
4. ❑ ❑ A heart defibrillator?
   If yes, when was it put in place?
   Date ____ / ____ / ____

YES NO

5. ❑ ❑ Does minimal activity cause you to be short of breath or fatigued?
6. ❑ ❑ Do you require treatment for kidney failure (including dialysis)? If yes,
   ❑ ❑ Does this condition, or treatment for this condition, affect your driving?

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SECTION E Continued

YES NO

7. ❑ ❑ Are you undergoing radiation or chemo therapy for cancer (malignancy)? If yes,
   ❑ ❑ Does this treatment affect your driving?
8. ❑ ❑ Have you required treatment for a problem with circulation in your arms or legs? If yes,

YES NO

What was the treatment?________________
____
____
When was the treatment?
____ / ____ / ____
❑ ❑ Does the circulation problem affect your ability to drive?

SECTION F

YES NO **Have you ever had (Circle which apply)**

1. ❑ ❑ Epilepsy - Convulsions - Seizures - Blackout spells - Fainting spells
   Date last event ____ / ____ / ____
   Number of events in the past 12 months__________
2. ❑ ❑ Have you had any surgical procedure to control seizures? Examples, brain surgery (including external laser treatment), implantation of vagal nerve stimulator
   What was the procedure?____________
   When was it performed?
   ____ / ____ / ____

YES NO

3. ❑ ❑ A head injury resulting in unconsciousness?
   Date ____ / ____ / ____
4. ❑ ❑ If you have diabetes, have you had a loss of consciousness, or required assistance due to a low blood sugar in the past year?
   When____ / ____ / ____
5. ❑ ❑ Have you been diagnosed with sleep apnea?
6. ❑ ❑ Have you been diagnosed with narcolepsy?
7. ❑ ❑ In the past year, have you had any significant changes in your ability to remember things?
8. ❑ ❑ In the past year, have you gotten lost while driving?

SECTION G

YES NO

1. ❑ ❑ Do you have difficulty turning your head from side to side?
2. ❑ ❑ Do you have problems with shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?
   ❑ ❑ Does it affect your ability to drive?
3. ❑ ❑ Have you been diagnosed with any condition or disease that causes shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?
   If yes, what is the condition?____________
   ____
   When was it diagnosed?
   ____ / ____ / ____
   ❑ ❑ Does it affect your ability to drive?
4. ❑ ❑ Do you require any of the following to get around? (Circle those that apply)
   -Cane/Crutch -Walker -Wheelchair
   -Scooter

YES NO

5. ❑ ❑ Have you had an extremity or part of an extremity [arm/hand/finger(s): leg/foot toe(s)] amputated, or do you have any extremities that are not fully developed?
   If yes, which extremity or part of an extremity?__________________________
   Is this condition the result of (please check)
   ______ amputation or
   ______ development?
   If an amputation, when was it performed? ____ / ____ / ____
6. ❑ ❑ Have you had a fall in the past three years?
7. ❑ ❑ Do you have any difficulty keeping your balance?
8. ❑ ❑ Do you have any difficulty walking?

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SECTION H

YES NO
1. ❑ ❑ **In the past year, h**ave you experienced any significant changes in your mood or feelings that interfere with your ability to drive?

YES NO
2. ❑ ❑ Have you attempted suicide?
Date ____ / ____ / ____

SECTION I

YES NO
1. ❑ ❑ Do you drink alcohol?
What is the date of your last drink?
Date____ / ____ / ____
2. On the occasions that you drink, how many drinks do you usually have?
❑ 1 drink
❑ 2 drinks
❑ 3 drinks
❑ 4 drinks
❑ 5 or more drinks

YES NO
3. ❑ ❑ Do you use illegal/illicit "street" drugs?
4. What was the date of your last use of illegal/illicit "street" drugs?
Date____ / ____ / ____
What drug(s) do you use?______________
____

Additional information /comments for any item on the questionnaire. ____

____

I certify that the information I have provided is true and complete to the best of my knowledge and belief.

____ YOUR SIGNATURE **(THIS QUESTIONNAIRE MUST BE SIGNED)**

________________________ TELEPHONE NUMBER(S)

_____ / _____ / _____ DATE

Per Maryland Vehicle Law, Transportation Article, 16-118, all medical information obtained will be kept CONFIDENTIAL and used to determine "the qualifications of an individual to drive." In some cases, "The Administration may use information in its records for the purpose of driver safety research, provided that personal information is not published or disclosed."

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