STATE OF GEORGIA
DEPARTMENT OF DRIVER SERVICES
MEDICAL REPORT

PHYSICIAN MUST COMPLETE FORM AND MAIL

THIS FORM MUST BE COMPLETED BY A PHYSICIAN AND THIS EXAMINATION MUST HAVE BEEN COMPLETED WITHIN THE PAST 12 MONTHS.

Patient Instructions **Please Print in Black Ink or Type**

1. Complete this side of the report with all of the information that applies to you.
2. Sign in the space provided below.
3. Have your physician complete the other sections of the form and mail the form directly to:
   Department of Driver Services, c/o Medical Unit, P. O. Box 80447, Conyers, Georgia 30013

PATIENT INFORMATION

Name_____

Street Address_____

City, State, Zip_____

Driver's License Number & State_____

Date of Birth_____

HISTORY

Please answer "yes" or "no" to all of the following questions. Explain each "yes" answer if your ability to drive is or could be affected.

Yes	No		
☐	☐	1.	Physical impairments?
☐	☐	2.	Has driver's license ever been revoked or denied?
☐	☐	3.	Neurological problems or disease?
☐	☐	4.	Head or spinal injuries?
☐	☐	5.	Seizures, fits, blackouts, convulsions, or fainting?
☐	☐	6.	Nervous, mental or psychiatric problem or disease?
☐	☐	7.	Cardiovascular problems or disease?
☐	☐	8.	Orthopedic, muscluoskeletal, bone, joint or muscle problems or disease?
☐	☐	9.	Diabetes?
☐	☐	10.	Visual problem or disease?
☐	☐	11.	Hearing problems?

Explain "yes" answers: _____

_____

_____

I hereby swear or affirm that the above answers are true to the best of my knowledge. I authorize Dr. _____ a licensed physician, to complete this examination and to provide further clarification or information about my medical condition to the Department of Driver Services. I agree that this medical report may be submitted to the Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State, and it also may be used for the guidance of the court when necessary.

_____ _____

DATE SIGNATURE

MEDICAL REPORT
PHYSICIAN'S STATEMENT

GENERAL INFORMATION:

How long has this individual been your patient? _____
When did you last examine patient?_____
Does the patient have a problem, condition, disorder or disease that could affect ability to drive? Explain_____
_____
Does patient require adaptive equipment to drive? Is so, what?_____
_____
What is your diagnosis?_____
_____
Does patient have hearing or other auditory problems? Explain_____
Conversational voice – distance in feet_____
Audiometric test results, if indicated_____
Is hearing aid worn? If yes, does it give adequate correction?_____

Complete the following questions 1 through 5. Complete the applicable section(s) if the problem or condition could affect the patient's ability to drive:

1. Does patient have a neurological or cerebrovascular condition or disease, blackout or fainting spells, seizures, convulsive disorder or epilepsy? _____ If so, complete the following section:
2. Does patient have cardiovascular disorder or hypertension? _____ If so, complete section B.
3. Does patient have nervous, mental, psychiatric or psychological problem?_____ If so, complete section C.
4. Does patient have orthopedic, muscluoskeletal, bone, joint or muscle problem. ____ If so, complete section D.
5. Does patient have diabetes?_____ If so, complete section E.

PLEASE LIST OTHER SIGNIFICANT FINDINGS WHICH IN YOUR OPINION WOULD HAVE ANY BEARING ON THIS PATIENT'S ABILITY TO DRIVE.

IMPORTANT: Questions six and seven require a yes or no answer.

6. Do you find any difficulties, problems, or diseases, other than 1 through 5 above, which would interfere with this person's ability to operate a motor vehicle safely? **Yes_____** **No**_____. If yes, please explain_____
_____
_____
7. In your opinion, is patient medically capable of operating a motor vehicle safely? **Yes**_____ **No**_____. If no, explain
_____
_____

_____ _____
DATE SIGNATURE OF PHYSICIAN

_____
NAME OF PHYSICIAN – PRINT IN FULL

_____
ADDRESS OF PHYSICIAN

_____
TELEPHONE NUMBER

SECTION A
NEUROLOGICAL, CEREBROVASCULAR, ALTERATION IN CONSCIOUSNESS

History of blackout or fainting spells? If yes, how often? Date of Last one_____
Has patient had epilepsy or convulsive seizures? If yes, date of onset and history. Frequency? Date of last one_____
_____
Medication prescribed, dosage and frequency_____
_____
Is patient compliant with medication regiment? Should patient continue taking medication?_____
Electroencephalogram? If yes, attach copy of EEG report._____
Parkinson Disease? Coordination normal? Any vertigo?_____

Any other neurological or cerebrovascular conditions which could affect patient's ability to operate a motor vehicle safely? If so, explain_____
_____

☐ If this box is checked, a neurological evaluation report must be made by a neurosurgeon or neurologist and be attached to this report.

SECTION B
CARDIOVASCULAR OR RESPIRATORY OR HYPERTENSIVE DISEASE

Functional Capacity (AHA)
- Class 1 – No limitation physical activity
- Class 2 – Slight limitation physical activity
- Class 3 – Marked limitation physical activity
- Class 4 – Complete limitation physical activity

Functional capacity classification? _____
Blood pressure? _____
Edema? _____
Dyspnea and/or angina? At rest? Slight exertion? Moderate? _____
Any syncope? Frequency and severity _____
Any syncopal episodes in past one (1) year?_____
Was last syncopal episode related to cardiovascular abnormalities or arrhythmias?_____

Any other findings or cardiovascular, respiratory, or hypertensive problems which could affect patient's ability to operate a motor vehicle safely? If so, explain_____

SECTION C
NERVOUS, MENTAL, PSYCHIATRIC, PSYCHOLOGICAL

Any nervous, mental, psychiatric or psychological problem that could impair driving ability? If yes, explain_____
_____
Would any prescribed medication likely impair driving ability? _____
Memory within normal limits? _____
History of frequent or intermittent confusion? _____
Any evidence of organic brain syndrome? _____
Any other findings or nervous, mental psychiatric or psychological which could affect patient's ability to operate a motor vehicle safely? If so, explain. _____
_____

☐ If this box is checked, a psychiatric evaluation report must be made by a psychiatrist or psychologist and be attached to this report, with recommendations.

SECTION D
ORTHOPEDIC, MUSCLUOSKELETAL

Explain any limitation of motion. _____
Any stiff or flail joints? Where? _____
Any spastic or paralyzed muscles? If yes, where? _____
Does patient use or need orthopedic appliances or supports? _____
_____

Any other findings or orthopedic or muscluoskeletal problems which could affect patient's ability to operate a motor vehicle safely? If so, explain. _____
_____

SECTION E
DIABETES

Age at onset _____
Patient take insulin or other hypoglycemic medication? _____
Medication, dosage, and frequency? _____
Is diabetes well controlled? _____
Patient ever been in a diabetic coma? Date of last coma? Warning symptoms?_____
Patient ever had hypoglycemic episode involving loss of consciousness or near loss of consciousness? Date of last episode?
_____