

DMV Medical Evaluation Form

Patient Information

Name:			
Date of Birth:		Phone Number:	
State:		Driver's License Number:	
Address:			

Medical History

Primary Diagnosis:	
Date of Diagnosis:	
Other Relevant Medical Conditions:	

Current Medications

Name of Medication	Dosage

Functional Assessment

Vision
<input type="checkbox"/> Normal <input type="checkbox"/> Impaired
Notes:
Hearing
<input type="checkbox"/> Normal <input type="checkbox"/> Impaired
Notes:

Mobility	
<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired
Notes:	
Cognition	
<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired
Notes:	
Recommendations	

Physician's Statement

I certify that the above information is true and accurate to the best of my knowledge. I have evaluated the patient's medical condition in relation to their ability to operate a motor vehicle safely.

Physician's Name:	
Physician's Signature:	
Date:	