STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

PHYSICIAN'S HEALTH REPORT

DO NOT use this form for Commercial Licensing Requirements.

546A

DMV USE ONLY
☐ Updated by _____

PHYSICIAN'S INSTRUCTIONS: Please complete the form and check "Yes" or "No" to each question and explain any "Yes" answer(s) in the space provided on the bottom of the form, or on another piece of paper. **Applicant must submit a completed health questionnaire every two years. Exception: Driving School Instructors must complete a health questionnaire every three years.**

PATIENT INFORMATION:

TRUE FULL NAME	DATE OF BIRTH	DRIVER LICENSE NUMBER

ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE
			( )

HEALTH QUESTIONS

	YES	NO
1. Does patient have difficulty recognizing the colors of red, green, and amber used in traffic signal lights and devices?	☐	☐
2. Is patient's side (peripheral) vision less than 70° for either eye?	☐	☐
3. Does patient have difficulty perceiving a forced whispered voice in the patient's better ear, without a hearing aid, at not less than five (5) feet?	☐	☐
4. Does patient have an acuity impairment in either eye that is not correctable to visual acuity of 20/40 or better?	☐	☐
5. Does patient:		
a. Have a missing foot, leg, hand, finger or arm?	☐	☐
b. Have any impairment of a hand, finger, arm, foot, leg or any other limitation?	☐	☐
6. Does patient have diabetes requiring insulin for control?	☐	☐
a. Has patient had a hypoglycemic episode or any other adverse reaction related to diabetes in the last three (3) years?	☐	☐
7. Has patient had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease?	☐	☐
If "yes," has patient had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last three (3) years?	☐	☐
8. Has patient been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis?	☐	☐
If "yes," is patient's respiratory condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
9. Has patient been diagnosed with high blood pressure of 160/90 or higher?	☐	☐
10. Has patient ever been diagnosed with rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease?	☐	☐
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
11. Has patient been diagnosed with any mental, nervous, organic or functional disease, or psychiatric disorder?	☐	☐
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
12. Has patient been diagnosed with epilepsy or any other condition that may cause loss of consciousness or loss of control?	☐	☐
If "yes," has there been a loss of consciousness or loss of control in the last three (3) years?	☐	☐
13. Does patient use a controlled substance, amphetamine, narcotic, or any other habit-forming drug?	☐	☐
If "yes" will the drug interfere with the patient's ability to drive a motor vehicle?	☐	☐
14. Does patient have a history or diagnosis of alcoholism?	☐	☐

Visual Acuity: Must be at least 20/40 in each eye with/without corrective lenses.

	UNCORRECTED	CORRECTED	CONTACTS?
Both	20/___	20/___	☐ Yes ☐ No
Left	20/___	20/___	Are the lenses well-adapted and
Right	20/___	20/___	tolerated? ☐ Yes ☐ No

Blood Pressure: If consistently above 160/90 mm. Hg., further tests may be necessary to determine if driver is qualified.

Systolic	Diastolic

EXPLAIN ANY "YES" ANSWERS HERE.

I have examined the above applicant and find that the patient has no physical impairment or condition that would preclude them from:
☐ Driving a House Car 40+ ft. ☐ Being a Driving School Instructor

PHYSICIAN'S NAME *(PLEASE PRINT)*	DATE OF LAST VISIT
	Mo Year
PHYSICIAN'S OFFICE ADDRESS	PHYSICIAN'S PHONE NUMBER
	( )

PHYSICIAN'S SIGNATURE	DATE OF EXAM	LICENSE OR CERTIFICATE NUMBER/ISSUING STATE
X		

I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct and I hereby give consent to the release of medical information by the above named physician.

DRIVER'S SIGNATURE	DATE
X	

DMV USE	EXAMINER'S SIGNATURE	ID NUMBER	OFFICE	DATE
	X			