U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ◯ M ◯ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Dr. Nicola Prof. Corp.

7380 W Sahara Blvd #100 Las Vegas, NV 89117 • Ph. (702) 252-7246 Fax (702) 251-9650

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date: _____

Date of Birth: ___/___/____ SSN: _____-_____-_____

I, _____ herby authorize Dr. Nicola Prof. Corp. and / or Dr. Vaughn to release any and all medical records to:

_____ (Company/ Employer Name)

Driver's Signature: _____ Date: _____

Dr. Nicola Prof. Corp.

7380 W Sahara Blvd #100 Las Vegas, NV 89117 • Ph. (702) 252-7246 Fax (702) 251-9650

_____**(client's initials) I have read the LAB/DOT policy restrictions and requirements.**

_____**(client's initials) I have read through the conditions list and acknowledge that I either do not have any of the conditions listed or I have furnished Nicola Chiropractic with the documentation needed to complete my physical exam. I understand that if I falsify any documents for my physical exam and I fail my exam I will not be issued a refund.**

This notice is to let you know that during your Commercial Driver License Exam / Drug Test you will not be treated for any medical conditions. You will not be establishing any doctor/patient relationship. You will be examined on a one time basis with the results being used to fill out your Department of Transportation forms. Nicola Chiropractic/ Nicola Prof Corp. accepts no liability for any injury or increase in pain as a result of the orthopedic and neurological examination that will be given as everything is done according to your pain tolerance level and never forced upon you. If you choose not to do a certain maneuver, it will be noted in your report. Thank you for your cooperation in this matter.

I understand the above and agree to be seen by Nicola Chiropractic/ Nicola Prof Corp. in order to complete my physical exam / drug test.

Driver's Name Printed: _____ Date: _____

Driver's Signature: _____

SSN: _____-_____-_____ Phone Number: (_____) _____-_____

Employer: _____

Contact: _____

Phone Number: _____

If you would like an email reminder prior to your certificate expiring please CLEARLY PRINT your email below

Email: _____

STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb/kg
Age _____
Male/Female
BMI _____
Collar size of shirt: S, M, L, XL, or _____ inches/cm
Neck circumference* _____ cm

1. Snoring
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No

2. Tired
Do you often feel tired, fatigued, or sleepy during daytime?
Yes No

3. Observed
Has anyone observed you stop breathing during your sleep?
Yes No

4. Blood pressure
Do you have or are you being treated for high blood pressure?
Yes No

5. BMI
BMI more than 35 kg/m^2?
Yes No

6. Age
Age over 50 yr old?
Yes No

7. Neck circumference
Neck circumference greater than 40 cm?
Yes No

8. Gender
Gender male?
Yes No

* Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
Frances Chung, F.R.C.P.C., Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.#*
Anesthesiology 2008; 108:812–21

Nicola Chiropractic

DOT / Drug Test Intake Form

Date: _____

- **Patient Name:** _____
- **Company:** _____
- **Would you like us to contact your company for a group /corporate account?:** Y / N
- **If yes, please provide contact info. Name:** _____

  Email / Number: _____
- **Have you ever had any surgeries?:** Y / N
- **Have you ever been involved in a work related or non work related accident?:** Y / N
- **Have you been involved in automobile accident lately?:** Y / N
- **Do wear corrective lenses?:** Y / N
- **Are you being treated for diabetes?:** Y / N
- **Do you have any other health condition?:** Y / N

Signature _____ **Date:** _____