

# PHYSICAL EXAMINATION

(VALID FOR NOT MORE THAN THREE YEARS FROM DATE OF EXAM)

PLEASE PRINT

DRIVER'S NAME <i>Last</i>	First	Middle	(AREA CODE) TELEPHONE NUMBER		
STREET ADDRESS		CITY	STATE	ZIP	DATE OF BIRTH

**TO BE COMPLETED BY MEDICAL EXAMINER** *(Please Print)*

Answer each question yes or no where appropriate. The medical examiner should be aware of the rigorous physical demands and mental and emotional responsibilities placed on the driver of a limousine vehicle. In the interest of public safety the medical examiner is required to certify that the driver does not have any physical, mental, or organic defect of such a nature as to affect the driver's ability to operate a limousine vehicle.

**Health History:**

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Weight: \_\_\_\_\_ lbs.

- |   |   |   |
|---|---|---|
| Yes No<br><input type="checkbox"/> <input type="checkbox"/> Diabetes<br><input type="checkbox"/> <input type="checkbox"/> Psychiatric disorder<br><input type="checkbox"/> <input type="checkbox"/> Cardiovascular disease<br><input type="checkbox"/> <input type="checkbox"/> Head or spinal injuries<br><input type="checkbox"/> <input type="checkbox"/> Seizures, fits, convulsions, or fainting<br><input type="checkbox"/> <input type="checkbox"/> Any other nervous disorder | Yes No<br><input type="checkbox"/> <input type="checkbox"/> Muscular disease<br><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> <input type="checkbox"/> Asthma<br><input type="checkbox"/> <input type="checkbox"/> Kidney disease<br><input type="checkbox"/> <input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> <input type="checkbox"/> Gastrointestinal ulcer | Yes No<br><input type="checkbox"/> <input type="checkbox"/> Nervous stomach<br><input type="checkbox"/> <input type="checkbox"/> Syphilis<br><input type="checkbox"/> <input type="checkbox"/> Gonorrhoea<br><input type="checkbox"/> <input type="checkbox"/> Extensive confinement by illness or injury<br><input type="checkbox"/> <input type="checkbox"/> Suffering from any other disease<br><input type="checkbox"/> <input type="checkbox"/> Permanent defect from illness, disease or injury |
|---|---|---|

If the answer to any of the above is yes, explain in General Comments section below.

**General appearance and development:** Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**Vision:** For distance: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_  Without corrective lenses  With corrective lenses, if worn

Horizontal field of vision: Right \_\_\_\_\_ Left \_\_\_\_\_

Evidence of disease or injury:  Right \_\_\_\_\_  Left \_\_\_\_\_

Color test \_\_\_\_\_

**Hearing:** Right ear \_\_\_\_\_ Left ear \_\_\_\_\_

Disease or injury \_\_\_\_\_

**Audiometric test:** *(If audiometer is used to test hearing)* Decibel loss at 500 Hz \_\_\_\_\_ at 1,000 Hz \_\_\_\_\_ at 2,000 Hz \_\_\_\_\_

**Throat:** \_\_\_\_\_

**Thorax:** Heart \_\_\_\_\_

If organic disease is present, is it fully compensated? \_\_\_\_\_

Blood pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

Pulse: Before exercise \_\_\_\_\_ Immediately after exercise \_\_\_\_\_

Lungs: \_\_\_\_\_

**Abdomen:** Scars \_\_\_\_\_ Abnormal masses \_\_\_\_\_ Tenderness \_\_\_\_\_

Hernia:  Yes No If so, where? \_\_\_\_\_ Is truss worn? \_\_\_\_\_

**Gastrointestinal:** Ulceration or other disease \_\_\_\_\_

**Genito-Urinary:** Scars \_\_\_\_\_

**Reflexes:** Romberg \_\_\_\_\_

Pupillary \_\_\_\_\_ Light Right \_\_\_\_\_ Left \_\_\_\_\_

Accommodation: Right \_\_\_\_\_ Left \_\_\_\_\_

Knee Jerks: Right: Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_

Left: Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_

**Extremities:** Upper \_\_\_\_\_ Lower \_\_\_\_\_ Spine \_\_\_\_\_

**Laboratory and other** Urine: Spec. Gr. \_\_\_\_\_ Alb. \_\_\_\_\_ Sugar \_\_\_\_\_

Other laboratory data (Serology, etc.) \_\_\_\_\_

**special findings:** Radiological data \_\_\_\_\_ Electrocardiograph \_\_\_\_\_

General Comments: \_\_\_\_\_

Check here if NOT qualified

Medical Examiner \_\_\_\_\_ License/Cert. No. & State \_\_\_\_\_  
PRINT NAME & TITLE

Address \_\_\_\_\_

Medical Examiner **X** \_\_\_\_\_ Date of Examination \_\_\_\_\_  
SIGNATURE MUST APPEAR HERE