REVIEW OF SYSTEMS: Please complete and bring to DOT exam visit

LAST NAME:_____FIRST:_____MI:_____

DOB: (MONTH, DAY, YEAR)_____/_____/_____AGE:_____

ADDRESS:_____CITY_____STATE:_____

ZIP CODE:_____

DRIVERS LICENSE NUMBER_____STATE OF ISSUE:_____

PLEASE EXPLAIN WHAT TYPE OF COMMERCIAL VEHICLE YOU OPERATE:

_____

Who is your primary care physician? Name and Office location:_____

_____

List any medical provider you have seen in the last 5 years._____

_____

Have you been hospitalized or had any surgeries within the last 5 years? YES/NO.

If yes, please explain:_____

_____

_____

Please list any medications you are taking or have taken within the last 30 days. Please include non-prescription medications and any herbal supplements including vitamins._____

_____

_____

Do you have any allergies to medications, foods or insect stings? YES/NO If yes, explain:_____

_____

Have you had any substance abuse driving incidents within the last 5 years? YES/NO. If YES, please explain._____
_____
_____

Have you ever been treated for any behavioral health issues? YES/NO. If YES, please explain:_____
_____
_____

Please indicate yes or no to the following questions. If you indicate YES to ant of the questions, please explain.

GENERAL

Have you had any recent night sweats, fevers or chills,? Y/N

Have you had any recent changes in your appetite? Y/N

Have you had any abnormal or unusual weight gain or loss? Y/N

VISION

Do you wear glasses or contact lenses? Y/N

Have you ever had cataract or Lasik surgery on your eyes? Y/N

Have you ever been treated for any eye injuries? Y/N

Date of last eye exam:_____

Do you have any blurry vision? Y/N

Do you have any double vision? Y/N

Do you have loss of vision in either eye? Y/N

Are you color blind? Y/N

EAR NOSE AND THROAT

Do you wear a hearing aid? Y/N

Do you have any significant hearing loss that you know of? Y/N

Have you had any surgery on your ears? Y/N

Are you exposed to a lot of loud noises? Y/N

Have you ever had chronic ear problems requiring long term medical management? Y/N

Have you ever been diagnosed with Minear's Disease? Y/N

Do you suffer from seasonal allergies such as hay fever, sinusitis, rhinitis , sore throat or nasal drainage on a chronic or recurrent basis? Y/N

Have you ever had any surgeries on your sinuses? Y/N

NEURO

Do you have a diagnosis of Migraines, Epilepsy, Dementia, or any type of Neuropathy? Y/N

Do you have headaches? How often? Y/N

Have you ever had head trauma/injury? If so, when? Y/N

Do you have trouble concentrating or diagnosis of ADHD? Y/N

Do you have a history of seizures? Y/N

Have you ever had a stroke or TIA? Y/N

Have you ever been treated for a head injury? Y/N

Do you suffer from any recurrent headaches, migraines, cluster headaches or any type of head pain? Y/N

Do you suffer from any type of dizziness? Y/N

Have you ever been diagnosed or treated for Multiple Sclerosis, Parkinson's, Alzheimer's or other neurological disorders? Y/N

RESPIRATORY

Have you ever been treated for TB? Y/N

Do you smoke? Y/N If yes, how many packs per day and for how long?

If you used to smoke, please indicate the last year you smoked.

Have you ever been diagnosed with COPD, Emphysema, Asthma or Sleep apnea? Y/N

Do you ever experience SOB or get easily winded while perform simple tasks? Y/N

Do you snore or have pauses in your breathing while sleeping? Y/N

Do you ever experience excessive day time sleepiness? Y/N

Do you have frequent/chronic coughing? Y/N

CARDIAC

Have you ever been diagnosed with Heart Disease, High cholesterol, Heart murmur? Y/N

Do you have a pace maker? Y/N

Do you have an implanted defibrillator? Y/N

Have you ever had open heart surgery? Y/N

Have you ever had a heart attack? Y/N

Have you ever had a stent placed? Y/N

Have you ever had a heart catheterization? Y/N

Have you ever been diagnosed with CHF (congestive heart failure)? Y/N

Do you have any chest pain or shortness of breath while at rest or with minimal work? Y/N

Have you ever fainted or blacked out? Y/N

Do you experience shortness of breath while lying down? Y/N

Do you ever have unexplained swelling in your legs or ankles? Y/N

Do you ever experience pain in your legs after walking a short distance? Y/N

GASTRO

Do you ever experience black stools, bloody stools or changes in your bowel habits? Y/N

Have you ever had any surgeries on your abdomen? Y/N

Have you ever had a colonoscopy? Y/N

Have you ever had a hernia? Y/N

MUSCULOSKELETAL

Are you currently experiencing and pain or numbness in your arms, hands, fingers, legs, feet or toes? Y/N

Have you ever been diagnosed with (RLS) Restless Leg Syndrome? Y/N

Are you currently suffering from any pain in your neck, back or legs which interfere with your ability to lift objects over 50 pounds? Y/N

Do you currently wear any type of prosthetic device (artificial limb)? Y/N

ENDOCRINOLOGY

Have you ever been diagnosed with diabetes? Y/N

Have you ever been diagnosed with a thyroid disorder? Y/N

Have you ever been treated for obesity or being overweight? Y/N

PHSYCHIATRIC

Do you have a history of depression, anxiety or other emotional disorders? Y/N

Have you ever been treated for or diagnosed with Post Traumatic Stress Disorder (PTSD)? Y/N

Have you ever been hospitalized for depression, anxiety, or other behavioral health issues? Y/N

Have you ever attempted suicide? Y/N

Have you recently lost pleasure or interest in things which you once found exciting? Y/N

SUBSTANCE ABUSE:

Do you consume alcohol? Y/N

How many drinks do you have on a monthly, weekly, daily basis?

Do you use prescription medications for recreational use? Y/N

Do you smoke or ingest marijuana? Y/N

Do you use or take any illegal substances? Y/N

MISCELLANEOUS

Have you been diagnosed or being treated for any conditions not listed above? Y/N