Motor Vehicle Administration
6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

Medical Advisory Board Health Questionnaire

The Medical Advisory Board (MAB) of the Maryland Motor Vehicle Administration has been asked to review your medical status as it relates to driving. A comprehensive medical history is needed for this assessment. Please complete this questionnaire carefully, as instructed below, for our Medical Advisory Board physicians' review.

INSTRUCTIONS

1. Please print all information legibly.
2. Mark the appropriate YES or NO box in the following manner: [X]
3. Use the following format for questions requiring a date: MM / DD / YYYY. For example: 11/26/2000
4. Please answer each question to the best of your ability. Space has been provided on the form for you to write additional information or comments you believe would help us understand your medical condition.
5. All medical information will be kept confidential as in the traditional doctor/patient relationship, and used only to assess driving safety.
6. If you want to provide additional information on any questionnaire item, use the space provided at the end of the questionnaire.

SECTION A

DRIVER LICENSE IDENTIFICATION NUMBER	TODAY'S DATE
___-___ ___ ___-___ ___ ___-___ ___ ___-___ ___ ___	____ / ____ / ____

LAST NAME FIRST MIDDLE FORMER

DATE OF BIRTH	SEX (Circle)	HEIGHT	WEIGHT	HOW MANY YEARS HAVE YOU HAD A DRIVERS'S LICENSE?
_____ / _____ / _____	M F			

EDUCATION (Circle highest grade completed) (Optional)

1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4	1 2 3 >4
ELEMENTARY	HIGH	COLLEGE	POST GRADUATE

REASONS FOR MEDICAL ADVISORY BOARD REVIEW

LEISURE ACTIVITIES / HOBBIES (OPTIONAL)

SECTION B

1. Are you currently (Circle) Employed Unemployed Retired Disabled

Responses to the following questions in Section B are optional.

1a. If employed, list occupation(s). _____

1b. How long have you been employed in the current position(s)? _____

1c. If unemployed, retired, or disabled list last occupation(s). _____

YES NO

2. ❑ ❑ Are you currently in school? If yes (Circle) Full-time Part-time

SECTION C

Have you taken any of the following medications regularly in the last 12 months?

YES NO

1. ❑ ❑ Medicine for seizures or convulsions
2. ❑ ❑ Insulin for diabetes
   - 2a. Date of your last blood glucose & HbA1C test ___ / ___ / ___
   - 2b. Test results: Glucose _____ HbA1C tests _____
3. ❑ ❑ Oral medicine for diabetes
4. ❑ ❑ Heart medicine
5. ❑ ❑ Medication for narcolepsy
6. ❑ ❑ Medication for multiple sclerosis
7. ❑ ❑ Medication for Parkinson's Disease
8. ❑ ❑ Medication for panic disorder
9. ❑ ❑ Medication for alcohol abuse
10. ❑ ❑ Medication for chronic pain
11. ❑ ❑ Medication for memory problems

YES NO

12. ❑ ❑ Medication for schizophrenia
13. ❑ ❑ Do you require portable oxygen?
14. *List names of <u>all</u> medicines taken regularly (at least once a week). Please check labels on containers.*
    - 14a. _____
    - 14b._____
    - 14c. _____
    - 14d. _____
    - 14e. _____
    - 14f. _____
15. What surgical operations have you had?
    - 15a. Condition _____
    - 15b. Year _____
    - 15c. Condition _____
    - 15d. Year_____
    - 15e. Condition _____
    - 15f. Year_____
16. Primary Care Physician_____
    - 16a. Phone Number (_____)_____

SECTION D

YES NO **Have you <u>ever</u> had**

1. ❑ ❑ Temporary loss of vision in either eye?
2. ❑ ❑ Glaucoma (high pressure in the eye)?
3. ❑ ❑ Cataracts?
4. ❑ ❑ Serious eye injury? Date ___ / ___ / ___
5. ❑ ❑ Eye surgery? (including laser surgery) ___ / ___ / ___
6. ❑ ❑ Blindness in either eye?
   - 6a. Age of onset _____
7. ❑ ❑ Loss of side (peripheral) vision?

During the <u>past 12 months</u> have you had

8. ❑ ❑ Any difficulty seeing in reduced light (night vision)?

YES NO

9. ❑ ❑ Have you had a decrease in vision in one or both eyes?
10. ❑ ❑ Have you had blurred or double vision?
11. ❑ ❑ Have you had trouble estimating distance when driving?
12. ❑ ❑ Have you been missing road signs, traffic signals, etc?
13. ❑ ❑ Do you have any other eye or vision problem(s) not covered above?
    - 13a. If yes, please describe_____ _____

SECTION E

YES NO **Have you <u>ever</u> had**

1. ❑ ❑ A heart attack? If yes,
   - 1a. Year(s)_____
2. ❑ ❑ Do you have? A heart pacemaker?
   - 2a. If yes, when was it put in place? Date ____ / ____ / ____
3. ❑ ❑ A heart defibrillator?
   - 3a. If yes, when was it put in place? Date ____ / ____ / ____

YES NO

4. ❑ ❑ A stroke or "mini stroke" (TIA)?
   - 5a. Year(s)_____
5. ❑ ❑ Does minimal activity cause you to be short of breath?
6. ❑ ❑ Do you require treatment for kidney failure (including dialysis)? If yes,
   - ❑ ❑ 6a. Does this condition, or treatment for this condition, affect your driving?

SECTION E Continued

YES NO

7. ❑ ❑ Are you undergoing radiation or chemo therapy for cancer (malignancy)? If yes,
   ❑ ❑ 7a. Does this treatment affect your driving?
8. ❑ ❑ Have you required treatment for a problem with circulation in your arms or legs? If yes,

YES NO

8a. What was the treatment?_____
_____
_____
8b. When was the treatment?
____ / ____ / ____
❑ ❑ 8c. Does the circulation problem affect your ability to drive?

SECTION F

YES NO **Have you ever had (Circle which apply)**

1. ❑ ❑ Epilepsy - Convulsions - Seizures - Blackout spells - Fainting spells
   1a. Date last attack ____ / ____ / ____
   1b. Number of attacks in the past 12 months_____
2. ❑ ❑ If you have diabetes, have you had a loss of consciousness, or required assistance due to a low blood sugar in the past year?
   2a. When____ / ____ / ____
3. ❑ ❑ Have you had any surgical procedures to control seizures? Examples, brain surgery (including external laser treatment), implantation of vagal nerve stimulator
   3a. What was the procedure?_____
   3b. When was it performed?
   ____ / ____ / ____

YES NO

4. ❑ ❑ Severe headaches that affect driving?
5. ❑ ❑ A head injury resulting in unconsciousness?
   5a. Date ____ / ____ / ____
6. ❑ ❑ Slurred speech or difficulty writing or buttoning your clothes?
7. ❑ ❑ Difficulty walking or keeping your balance?
8. ❑ ❑ Any other neurologic problems not covered above?
   If yes, please describe
   8a. Condition _____
   8b. Date of onset ____ / ____ / ____
   8c. Treating Physician _____
   8d. Phone Number (_____)_____

SECTION G

YES NO

1. ❑ ❑ Do you have difficulty turning your head from side to side?
2. ❑ ❑ Do you have problems with shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?
   2a. What is the problem?_____
   _____
   ❑ ❑ 2b. Does it affect your ability to drive?
3. ❑ ❑ Have you been diagnosed with any condition or disease that causes shaking, numbness, weakness or tingling in your arms and hands and/or legs and feet?
   3a. If yes, what is the condition?_____
   _____
   3b. When was it diagnosed?
   ____ / ____ / ____
   ❑ ❑ 3c. Does it affect your ability to drive?

YES NO

4. ❑ ❑ Do you require any of the following to get around? (Circle those that apply)
   -Cane/Crutch -Walker -Wheelchair -Scooter
5. ❑ ❑ Have you had an extremity or part of an extremity (arm/hand/finger(s): leg/foot/toe(s) amputated, or do you have any extremities that are not fully developed?
   5a. If yes, which extremity or part of an extremity?_____
   5b. Is this condition the result of (please check)
   _____ amputation or
   _____ development?
   5c. If an amputation, when was it performed? ____ / ____ / ____
6. ❑ ❑ Have you had a fall in the past three years?

SECTION H

YES NO

1. ❑ ❑ Have you experienced any changes in your mood or feelings that interfere with your ability to drive?
2. ❑ ❑ Have you ever attempted suicide?
   2a. Date ____ / ____ / ____
3. ❑ ❑ Have you noticed a change in your ability to remember things?
4. ❑ ❑ In the past year, have you gotten lost driving?
5. Have you been diagnosed with
   ❑ ❑ 5a. Sleep Apnea
   ❑ ❑ 5b. Narcolepsy

SECTION I

YES NO

1. ❑ ❑ Do you drink alcohol?
   1a. What is the date of your last drink?
   Date____ / ____ / ____
2. On the occasions that you drink, how many drinks do you usually have?
   2a. ❑ 1 drink
   2b. ❑ 2 drinks
   2c. ❑ 3 drinks
   2d. ❑ 4 drinks
   2e. ❑ 5 or more drinks
3. ❑ ❑ Do you use illegal/illicit "street" drugs? If yes, do you use them
   2a. ❑ Daily
   2b. ❑ Weekly
   2c. ❑ Occasionally
   2d. ❑ Rarely
4. What was the date of your last use of illegal/illicit "street" drugs? Date____ / ____ / ____
   4a. What drug(s) do/did you use?_____
   _____

Additional information /comments for any item on the questionnaire. _____

I certify that the information I have provided is true and complete to the best of my knowledge and belief.

_____ _____ ____ / ____ / ____

YOUR SIGNATURE (THIS QUESTIONNAIRE MUST BE SIGNED) TELEPHONE NUMBER DATE

PROHIBITION ON REDISCLOSURE

This information is confidential and is protected by the Maryland Motor Vehicle Law governing Medical Advisory Board cases and by Federal regulations (43 CFR Part 2) which prohibits anyone from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose