LOUISIANA DEPARTMENT OF PUBLIC SAFETY & CORRECTIONS
OFFICE OF MOTOR VEHICLES
MEDICAL EXAMINATION FORM
P. O. BOX 64886 • BATON ROUGE, LA 70896-4886

The bearer of this medical examination form is being required to undergo an examination by a physician. Authority for the requirement is based on laws of the State of Louisiana relating to the issuance of drivers' licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application, which is now pending.

NOTE TO APPLICANT: This medical examination form must be completed by your physician and returned to this office within 30 days from the "DATE ISSUED" indicated below. Failure to comply will result in the suspension of your driving privileges.

1. TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES

APPLICANT'S NAME _____ DOB _____ R/S_____ D/L#_____
ADDRESS _____ CITY _____
DATE ISSUED _____ MVCA'S INITIALS _____ BADGE# _____ OFFICE# _____
REMARKS: _____
_____

☐ **APPLICANT FAILED TO COMPLY WITHIN 30 DAYS.**

NOTE TO PHYSICIAN: In accordance with the provisions of R. S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by the physician. Incomplete forms may be rejected and could result in the denial of this applicant's driving privileges.

2. TO BE COMPLETED BY THE PHYSICIAN

HISTORY

1. Patient's Name: _____ Date of Birth: _____
2. Does patient have any medical or physical disorders? If yes, list the medical or physical disorders _____
3. Is patient taking any medication? _____ If yes, **list current medication and dosage** _____
4. Has patient had any past surgical procedures? _____ If yes, list the past surgical procedures _____
5. Has patient had any illness that could affect the ability to operate a motor vehicle safely? _____ If yes, describe the illness _____
6. Has patient's driving privileges ever been withdrawn for a medical or physical disorder? _____

VISION

1. What is patient's visual acuity without corrective lens? Right eye 20/_____ Left eye 20/_____ Both eyes 20/_____
2. Are corrective lens worn? _____ If yes, with corrective lens: Right eye 20/ _____ Left eye 20/ _____ Both eyes 20/ _____
3. What are patient's peripheral vision fields? _____ Right eye _____ Left eye _____

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green and amber?

☐ Yes ☐ No

HEARING

1. Does the patient have any hearing impairment? _____ If yes, describe the hearing impairment _____
2. Is a hearing aid worn? _____ If yes, does it give sufficient correction? _____

ORTHOPAEDIC

1. Does patient have any amputation or skeletal deficits that could interfere with the ability to operate a motor vehicle safely? _____ If yes, describe the deficits in detail _____
2. Does patient have stiff or frail joints? _____ If yes, describe _____
3. Does patient have spastic or paralyzed muscles? _____ If yes, describe _____
4. Does patient have any orthopedic appliances or supports? _____ If yes, list any device or support and how long used _____
5. Does this device provide adequate compensation for operating a motor vehicle safely? _____

CARDIOPULMONARY

1. Does patient have angina?_____ If yes, when does it occur?_____strenuous activity_____normal activity_____at rest_____
2. Does patient have dyspnea?_____If yes, when does it occur?_____strenuous activity_____normal activity_____at rest_____
3. Does patient have syncope?_____if yes, what is the frequency?_____duration_____last occurance_____
4. Does patient have dizziness?_____ describe_____

5. What is patient's blood pressure? 1st reading _____ 2nd reading _____
6. What is patient's pulse? Rate _____ Rhythm _____
7. Has patient had cardiovascular catheterization or surgery? _____ If yes, describe _____

List medications and dosage: _____

NEUROLOGICAL

1. Does patient have epilepsy? _____If yes, what type of seizures? _____ Date of last seizure? _____
   Are seizures completely controlled? _____ Is patient under regular medical care? _____
   What are the anticonvulsant serum blood levels? _____
2. Does patient have any signs of Parkinsonism? _____ If yes, describe condition and severity _____

   Is coordination normal? _____ If no, describe _____
3. Does patient have any neurological disorder? _____ If yes, describe _____

List medications and dosage: _____
Is patient reliable in taking medication and following medical regimen? _____

MENTAL

1. Does patient have symptoms of any mental disorder? _____ If yes, describe condition and severity at present _____

2. Has patient ever been treated in a mental hospital? _____ If yes, where and when _____
   What was diagnosis and cure? _____
3. Does patient use alcohol or drugs? _____ If yes, describe usage _____
4. Is patient mentally deficient? _____ If yes, what was highest grade attained in school? _____ age at attainment? _____
5. Does patient have sufficient regard for his/her personal safety as well as that of others to operate a motor vehicle safely? Give details _____
6. Is patient likely to act on sudden impulse without regard for the consequences of his/her behavior? ___
   Give details _____
7. On the basis of your examination and/or knowledge of this patient, do you recommend periodic psychiatric examinations? Give details _____

List medications and dosage: _____

DIABETES

1. Does patient have a history of diabetes? _____ If yes, is insulin taken? _____ is oral medication taken? _____
2. What are patient's laboratory studies? recent urine sugars _____ recent blood sugars _____
3. Has patient had any occurrences of diabetic coma? _____ If yes, give dates _____
4. Has patient had any occurrences of insulin shock? _____ If yes, give dates _____
5. Does patient have associated abnormalities? visual_____renal_____vascular_____neurological_____other_____ If yes, describe _____
6. Does patient have hypoglycemia? _____ If yes, describe treatment _____

List medications taken and dosage: _____
Is patient reliable in taking diabetes medication? _____ Is diabetes controlled? _____

3. TO BE SIGNED BY PATIENT

I hereby authorize the examining physician whose signature appears below to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date _____ Signature of Patient _____

4. TO BE COMPLETED, SIGNED AND DATED BY THE PHYSICIAN

PLEASE REFER TO "NOTE TO PHYSICIAN:" on the first page of this form. Are you this patient's treating physician? _____
In your opinion, from a medical standpoint, is it safe for this patient to operate a motor vehicle? _____
On the basis of your examination and/or knowledge of this patient, do you recommend periodic medical reports be submitted?
If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ other_____ Remarks: _____

Physician's Signature _____ Date _____
Physician's Printed Name _____ Telephone# _____
Physician's Address _____