STATE OF CALIFORNIA
DMV
Department of Motor Vehicles

546A

DMV USE ONLY
☐ Updated by _____

PHYSICIAN'S HEALTH REPORT

DO NOT use this form for Commercial Licensing Requirements.

PHYSICIAN'S INSTRUCTIONS: Please complete the form and check "Yes" or "No" to each question and explain any "Yes" answer(s) in the space provided on the form, or on another piece of paper. **Applicant must submit a completed health questionnaire every two years. Exception: Driving School Instructors must complete a health questionnaire every three years.**

SECTION 1 — PATIENT INFORMATION

TRUE FULL NAME	DATE OF BIRTH	DRIVER LICENSE NUMBER

ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE
			( )

SECTION 2 — HEALTH QUESTIONS

	YES	NO
1. Does patient have difficulty recognizing the colors of red, green, and amber used in traffic signal lights and devices?	☐	☐
2. Is patient's side (peripheral) vision less than 70° for either eye?	☐	☐
3. Does patient have difficulty perceiving a forced whispered voice in the patient's better ear, with or without a hearing aid, at not less than five (5) feet?	☐	☐
4. Does patient have an acuity impairment in either eye that is not correctable to visual acuity of 20/40 or better?	☐	☐
5. Does patient:		
a. Have a missing foot, leg, hand, finger or arm?	☐	☐
b. Have any impairment of a hand, finger, arm, foot, leg or any other limitation?	☐	☐
6. Does patient have diabetes requiring insulin?	☐	☐
a. Has patient had a hypoglycemic episode or any other adverse reaction related to diabetes in the last three (3) years?	☐	☐
7. Has patient had a heart attack, angina, coronary insufficiency, thrombosis, stroke, other heart problem, or cardiovascular disease?	☐	☐
If "yes," has patient had labored breathing, fainting, collapse, congestive heart failure, or other symptoms in the last three (3) years?	☐	☐
8. Has patient been diagnosed with a respiratory condition, such as emphysema, chronic asthma, or tuberculosis?	☐	☐
If "yes," is patient's respiratory condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
9. Has patient been diagnosed with high blood pressure of 140/90 or higher?	☐	☐
10. Has patient ever been diagnosed with rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease?	☐	☐
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
11. Has patient been diagnosed with any mental, nervous, organic or functional disease, or psychiatric disorder?	☐	☐
If "yes," is the condition likely to interfere with patient's ability to drive a motor vehicle safely?	☐	☐
12. Has patient been diagnosed with epilepsy or any other condition that may cause lapse of consciousness or loss of control?	☐	☐
If "yes," has there been a lapse of consciousness or loss of control in the last three (3) years?	☐	☐
13. Does patient use a controlled substance, amphetamine, narcotic, or any other habit-forming drug?	☐	☐
If "yes" will the drug interfere with the patient's ability to drive a motor vehicle safely?	☐	☐
14. Does patient have a history or diagnosis of alcoholism?	☐	☐

PHYSICIAN'S HEALTH REPORT (CONT.)

Visual Acuity: Must be at least 20/40 in each eye with/without corrective lenses.

UNCORRECTED		CORRECTED
Both	20/___	20/___
Left	20/___	20/___
Right	20/___	20/___

CONTACTS? ☐ Yes ☐ No

Are the lenses well adapted and tolerated? ☐ Yes ☐ No

Blood Pressure: If consistently 140/90 mm. Hg. or higher, further tests may be necessary to determine if driver is qualified.

Systolic | Diastolic

EXPLAIN ANY "YES" ANSWERS HERE

I have examined the applicant and found that the patient has no physical impairment or condition that would preclude them from:

☐ Driving a House Car 40+ feet
☐ Being a Driving School Instructor

PHYSICIAN'S NAME *(PLEASE PRINT)*	DATE OF LAST VISIT
	Mo. _____ Year _____
PHYSICIAN'S OFFICE ADDRESS	PHYSICIAN'S PHONE NUMBER
	( )

PHYSICIAN'S SIGNATURE	DATE OF EXAM	LICENSE OR CERTIFICATE NUMBER/ISSUING STATE
X		

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I hereby give consent to the release of medical information by the above named physician.

DRIVER'S SIGNATURE	DATE
X	

DMV USE	EXAMINER'S SIGNATURE	ID NUMBER	OFFICE	DATE
	X			

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