

DRIVER MEDICAL QUESTIONNAIRE

Southern Trace Underwriters

Patient's Name _____ **Date of Birth** _____
Address _____ **City and State** _____ **Zip Code** _____

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to Southern Trace Underwriters, 101 Continental Place, Suite 200, Brentwood, TN. This authorization is valid for 3 years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to Southern Trace Underwriters at the above address.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

TO BE COMPLETED BY PHYSICIAN

EXPLAIN ALL "YES" RESPONSES IN REMARKS

	YES	NO		YES	NO
<i>EYESIGHT</i>			<i>LIMBS</i>		
1. Has patient lost use of or sight of either eye?	<input type="checkbox"/>	<input type="checkbox"/>	1. Has patient lost an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is peripheral vision restricted?	<input type="checkbox"/>	<input type="checkbox"/>	2. Has patient lost use of an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is patient color blind?	<input type="checkbox"/>	<input type="checkbox"/>	<i>DIABETES</i>		
4. Does patient have cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	1. Is patient diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are deficiencies corrected by glasses/contacts?	<input type="checkbox"/>	<input type="checkbox"/>	2. If yes, give type (I or II) _____		
<i>HEARING</i>			3. Is diabetes controlled with medication?	<input type="checkbox"/>	<input type="checkbox"/>
1. Is patient able to hear normal conversation level?	<input type="checkbox"/>	<input type="checkbox"/>	<i>BLOOD PRESSURE</i>		
2. Is hearing aid used?	<input type="checkbox"/>	<input type="checkbox"/>	1. Is patient being treated for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
<i>EPILEPSY</i>			2. Last reading _____		
1. Has patient ever been treated for epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<i>GENERAL</i>		
2. If yes, what type? _____			1. Is patient being treated or taking medication for any neurological, mental, or emotional problem?	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of last seizure _____			2. Does patient suffer from any neuromuscular disease?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is condition adequately controlled w/medication?	<input type="checkbox"/>	<input type="checkbox"/>	3. Is patient being treated for drug or alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
<i>HEART</i>					
1. Is patient being treated for heart disease?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Does patient have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Does patient take medication for heart problems?	<input type="checkbox"/>	<input type="checkbox"/>			

REMARKS _____

What is your opinion as to patient's ability to safely operate a motor vehicle?
 Above Average _____ Average _____ Below Average _____

STAMP/PRINT NAME OF PHYSICIAN SIGNATURE OF PHYSICIAN DATE