



INTERNATIONAL HOT ROD ASSOCIATION  
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 PHONE: 419-663-6666 FAX: 419-668-6601

### MEDICAL PHYSICAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (For each "yes" checked describe conditions in remarks)

| Y | N | CONDITION                         | Y | N | CONDITION                         | Y | N | CONDITION                          | Y | N | CONDITION                         |
|---|---|-----------------------------------|---|---|-----------------------------------|---|---|------------------------------------|---|---|-----------------------------------|
|   |   | a. frequent or severe headaches   |   |   | g. heart trouble                  |   |   | m. nervous trouble of any sort     |   |   | s. medical rejection from service |
|   |   | b. dizziness or fainting spells   |   |   | h. high or low blood pressure     |   |   | n. any drug or narcotic habit      |   |   | t. admission to hospital          |
|   |   | c. unconsciousness for any reason |   |   | i. stomach trouble                |   |   | o. excessive drinking habit        |   |   | u. rejection for life insurance   |
|   |   | d. eye trouble except glasses     |   |   | j. kidney stone or blood in urine |   |   | p. attempted suicide               |   |   | v. record of traffic convictions  |
|   |   | e. hay fever                      |   |   | k. sugar or albumin in urine      |   |   | q. motion sickness requiring drugs |   |   | w. record of other convictions    |
|   |   | f. asthma                         |   |   | l. epilepsy or fits               |   |   | r. military medical discharge      |   |   | x. other illnesses                |

**REMARKS:** (if no changes since last report, so state) \_\_\_\_\_

### MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

| Date | Name of Physician Consulted | Reason |
|------|-----------------------------|--------|
|      |                             |        |
|      |                             |        |
|      |                             |        |
|      |                             |        |

SIGNATURE OF APPLICANT

DATE

**APPLICANTS' DECLARATION:** *I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for insurance of any IHRA certificate to me.*

### REPORT OF MEDICAL EXAMINATION

| NORMAL | ABNORMAL | CHECK EACH ITEM IN APPROPRIATE BOX                                 |   |
|--------|----------|--|---|
|        |          | 1. Head, face, neck and scalp                                      | <b>NOTES:</b> Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form. |
|        |          | 2. Nose  |   |
|        |          | 3. Sinuses   |   |
|        |          | 4. Mouth and throat  |   |
|        |          | 5. Ears, general (internal and external canals)                    |   |
|        |          | 6. Ear Drums (perforation)   |   |
|        |          | 7. Eyes, general (visual activity under items 50 & 51)             |   |
|        |          | 8. Ophthalmoscopic   |   |
|        |          | 9. Pupils (equality and reaction)                                  |   |
|        |          | 10. Ocular mobility (associated parallel movement, mystaginus)     |   |
|        |          | 11. Lungs and chest (including breasts)                            |   |
|        |          | 12. Heart (thrust, size, rhythm, sounds)                           |   |
|        |          | 13. Vascular system  |   |
|        |          | 14. Abdomen and viscera (including hernia)                         |   |
|        |          | 15. Anus and rectum (hemorrhoids, fistula, prostate)               |   |
|        |          | 16. Endocrine system   |   |
|        |          | 17. G-U system   |   |
|        |          | 18. Upper and lower extremities (strength, range of motion)        |   |
|        |          | 19. Spine other musculoskeletal                                    |   |
|        |          | 20. Identifying body marks, scar, tattoos                          |   |
|        |          | 21. Skin and lymphatic   |   |
|        |          | 22. Neuralgic (tendon reflexes, equilibrium, senses, coordination) |   |
|        |          | 23. Psychiatric (specify any personality deviation)                |   |
|        |          | 24. General Systemic   |   |

| Corrective lens required while driving  |                                     | FIELD OF VISION   | DISTANT VISION                         |                | NEAR VISION              |
|---|-------------------------------------|---|--|----------------|--------------------------|
| <input type="checkbox"/> NO * if previously "yes", please include explanation of change   | <input type="checkbox"/> YES        | <input type="checkbox"/> Normal   | Right eye                              | 20/            | 20/                      |
|   |                                     | <input type="checkbox"/> Abnormal   | Left eye                               | 20/            | 20/                      |
|   |                                     |   | Both eyes                              | 20/            | 20/                      |
| <b>FIELD OF VISION</b>  |                                     | <b>BLOOD SUGAR TEST</b><br>(both fasting and 2 hour post prandial, required only if sugar is found in urine No S.I. Units)) |  |                |                          |
| RIGHT EYE   | LEFT EYE                            | FASTING   | 2-HOUR P.P.                            | HgA 1C         | COMMENTS                 |
| <b>BLOOD PRESSURE</b>   |                                     | <b>PULSE (Wrist)</b>  |  |                |                          |
| Recumbent MM Mercury  | Systolic                            | Diastolic   | Resting                                | After Exercise | 2 minutes after exercise |
| <b>URINALYSIS</b>   |                                     | <b>ECG (Date)</b>   | <b>OTHER TESTS</b>                     |                |                          |
| Albumen   | Sugar                               |   |  |                |                          |
| <b>DISQUALIFYING DEFECTS/LIMITATIONS:</b>   |                                     |   |  |                |                          |
| <b>COMMENTS ON HISTORY AND FINDINGS:</b>  |                                     |   |  |                |                          |
| APPLICANTS NAME:  |                                     |   | FURTHER EVALUATION REQUIRED (EXPLAIN): |                |                          |
| PHYSICALLY ACCEPTABLE   |                                     |   |  |                |                          |
| <b>MEDICAL EXAMINER'S DECLARATION:</b> I hereby certify that I personally examined the applicant named on this medical examination report, and that this report and any attachment embodies my findings completely and correctly. |                                     |   |  |                |                          |
| EXAMINATION DATE  | MEDICAL EXAMINER'S NAME AND ADDRESS |   | MEDICAL EXAMINER'S SIGNATURE           |                |                          |