**Dot Physical Form PDF**

**Driver Information**

* Name: [Text Field]
* Date of Birth: [Text Field]
* Social Security Number: [Text Field] (Optional)
* Driver's License Number and State: [Text Field]

**Medical History**

* Have you ever had any of the following conditions? (Checkboxes for each)
  + Heart disease
  + High blood pressure
  + Epilepsy
  + Diabetes
  + Other neurological disorders

**Vision**

* Right Eye: [Text Field] (Acuity)
* Left Eye: [Text Field] (Acuity)
* Both Eyes: [Text Field] (Acuity)
* Corrective Lenses Required? [Checkbox]

**Hearing**

* Can hear a forced whisper from 5 feet away: [Checkbox] Yes [Checkbox] No
* Hearing Aid Required? [Checkbox]

**Blood Pressure/Pulse Rate**

* Blood Pressure: [Text Field]
* Pulse Rate: [Text Field]
* Regular or Irregular: [Dropdown Menu]

**Laboratory Tests (If Applicable)**

* Urinalysis (For specific gravity, glucose, protein, blood): [Text Fields]
* Other Tests: [Text Field]

**Physical Examination**

* Detailed checklist for each body system to be examined:
  + General Appearance
  + Eyes
  + Ears, Nose, Throat
  + Extremities
  + Heart
  + Lungs and Chest
  + Abdomen
  + Neurological

**Certification**

* Medical Examiner's Certification: [Text Field] (Statement of driver's medical fitness for duty)
* Examiner's Signature: [Signature Field]
* Date: [Date Field]