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]