OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

DRIVER MEDICAL EVALUATION QUESTIONNAIRE

Section I: Demographic and Employment Information

Driver Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)

Employment Category: ☐ Locally Employed Staff ☐ USDH ☐ Other: _____

Job Title/Section	Post

Type of Evaluation:	Type of Evaluation:
☐ Initial ☐ Periodic ☐ Follow-Up	☐ Full-Time/Higher Risk Vehicle Driver *(every 2 years)* ☐ Incidental Driver *(every 4 years)* ☐ Chauffeur ☐ Truck *(over 25K lbs)* ☐ Hazmat Transport ☐ Van/Bus *(15+ passengers)*

Section II: Health History

MEDICAL EVALUATION

Do you have any medical restrictions related to driving? i.e., have you ever been told by a health professional to avoid driving for any reason? ☐ Yes ☐ No	If "Yes", describe below
Do you have any medical restrictions related to performing certain job duties (i.e., have you ever been told by a health professional to avoid doing certain job tasks including lifting, standing for extended periods of time, bending, stooping, etc.)? ☐ Yes ☐ No	If "Yes", describe below
Are you under the care of a medical provider for any medical or mental health conditions? ☐ Yes ☐ No	If "Yes", describe below
Do you have any additional medical/mental health condition(s) for which you are not currently being treated or seen by a health professional? ☐ Yes ☐ No	If "Yes", describe below

MEDICAL CONDITIONS

(Are you under the care of a medical provider for any of the following medical conditions (select "yes" or "no"))

Sleep apnea, narcolepsy, or conditions that lead to drowsiness

Have you been diagnosed with sleep apnea, narcolepsy, or any condition that may cause daytime drowsiness or problems staying awake?
☐ Yes ☐ No

Diabetes, blood glucose abnormalities

Have you been diagnosed with diabetes or abnormal blood glucose? ☐ Yes ☐ No	How are you treated? ☐ Insulin-treated ☐ Non-insulin treated (oral or injectable meds) ☐ No current insulin or meds

Name of Examinee	DOB

Epilepsy, seizures, or conditions that lead to loss of consciousness

Have you been diagnosed with epilepsy, or have you ever had one or more seizures/episodes of loss of consciousness? ☐ Yes ☐ No	If "Yes", describe below

Other

List any additional medical or mental health condition(s) for which you are currently being treated.

MEDICATION

_____ (Initials)	I currently do not take any prescribed, over the counter, controlled, or other medications or supplements. (If initialed, move directly to VISION)

List any current medications/drugs taken either on a routine schedule or as needed. Include all prescribed medications, over-the-counter medications, controlled substances, and/or supplements.

Medication	Dose	How Often (*once a day, as needed, etc.*)	When Started (*mm-yyyy*)	Comments or Additional Information

VISION

☐ Yes ☐ No Have you ever been told by a health professional that you have a visual impairment?

☐ Yes ☐ No Do you wear glasses or contact lenses? **IF YES:** ☐ Yes ☐ No Do you wear them while driving?

☐ Yes ☐ No Have you ever had procedures to correct your vision?

☐ Yes ☐ No Have you ever been told by a health professional that you have other problems related to your vision or eyes (e.g., monocular vision, colorblindness, etc.)?

HEARING

☐ Yes ☐ No Have you ever been told by a health professional that you have hearing loss?

☐ Yes ☐ No Do you currently wear (or have you ever worn) hearing aids?

Section III: Physical Exam

Part I: Blood Pressure

STANDARD: Needs to be . 155/95. If above 155/95, see flow chart.
INSTRUCTIONS: If first reading is over 155/95, wait 15 min between readings; ensure proper cuff size; both feet on the floor, arm resting on table. Perform second BP, if needed. Report systolic and diastolic as numerical values. First Reading Second Reading (if needed). Report systolic and diastolic as numerical values.

First Reading		Second Reading	
Systolic: _____	Diastolic: _____	Systolic: _____	Diastolic: _____

Name of Examinee	DOB

Part II: Vision

STANDARD: At least 20/40 acuity (Snellen) required in each eye with, or without, correction. The horizontal field of vision must be 70 degrees with each eye, 140 degrees overall.
INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording the distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet (6.096 meters) as denominator. If the individual wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or needs to do so while driving, employee must provide sufficient evidence of good tolerance and adaption to their use.

NUMERICAL READINGS MUST BE PROVIDED

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION	Individual recognizes and distinguishes all lights on traffic control signals and devices showing standard red/green colors.*
Right Eye	20/ _____	20/ _____	20/ _____	☐ Yes ☐ No
Left Eye	20/ _____	20/ _____	20/ _____	
Both Eyes	20/ _____	20/ _____	20/ _____	*see Color Vision Instructions document

Part III: Hearing

STANDARD: 1. Must first perceive forced whisper voice > 5 feet (1.5 meters) with or without a hearing aid. 2. If needed, audiometric testing can be performed and average hearing loss (at 500Hz, 1000Hz, 2000Hz) should be 40dB in better ear.
INSTRUCTIONS: Always perform the whisper test first. If individual passes, the hearing section is complete. ONLY perform audiometric testing if needed. To calculate the average for the Hz values, add the readings for the frequencies and divide by three.

NUMERICAL READINGS MUST BE PROVIDED

Record distance from individual at which forced whispered voice can first be heard.

Right Ear	Left Ear		
_____ Per ☐ ft ☐ m	_____ Per ☐ ft ☐ m	☐ Pass ☐ Fail	If FAIL, perform audiometric testing (record hearing loss in dB)

	500 Hz	1000 Hz	2000 Hz	Average
Right Ear				
LeftEar				

Part IV: Tuberculosis Risk Assessment

STANDARD: All drivers require a risk assessment and should have a chest x-ray (if high or moderate risk) and other testing (if low risk) as required. All employees MUST complete the TB Risk Assessment Questionnaire and clinician must attach to this DME Questionnaire as a supplemental form.

Part V: Urinalysis

STANDARD: OPTIONAL, based on results of history in Section II.

NUMERICAL READINGS MUST BE PROVIDED

Urine Speciman	SP. GR. _____	Protein _____	Blood _____	Sugar _____

Part VI: Review of Symptoms

GENERAL	VISION/EYES	HEARING	CARDIOVASCULAR	RESPIRATORY
☐ Fever	☐ Pain	☐ Tinnitus	☐ Chest Pain	☐ Shortness of breath
☐ Chills	☐ Redness	☐ Hearing Change	☐ Palpitations	☐ Cough
☐ Dizziness	☐ Vision Change			☐ Pain with breath
☐ Weakness				☐ Hemoptysis
ENDOCRINE	**MENTAL HEALTH**	**MUSCULOSKELETAL**	**NEUROLOGICAL**	**OTHER**
☐ Flushing	☐ Irritability	☐ Joint Pain	☐ Headache	☐ _____
☐ Skin Changes	☐ Anxiety	☐ Back Pain	☐ Numbness	☐ _____
☐ Temperature Instability	☐ Depression	☐ Neck Pain	☐ Tingling	☐ _____
☐ Swelling	☐ Mood Changes		☐ Weakness	☐ None

If any boxes are checked (except "None"), please describe below.

Name of Examinee	DOB

Part VII: Clinical Evaluation

	Normal?	Abnormal?	If abnormal, provide details.
General (alert/oriented, general mental status)	☐	☐	
Cardiovascular/Heart	☐	☐	
Respiratory System	☐	☐	
Musculoskeletal	☐	☐	
Other	☐	☐	
Other	☐	☐	

Part VIII: Additional Forms

If the individual has history of sleep disorder, diabetes, seizures, visual impairment or hearing impairment, please follow the supplemental procedures.

Check boxes for each additional form that needs to be completed (listed in toolkit)	☐ Diabetes
	☐ Seizures/Epilepsy
	☐ Vision (monocular. etc.)
	☐ Other, follow-up as recommended (sleep disorder, cardivascular, etc.)

Section IV: Local or HU Medical Provider/Clinician Recommendation

Based on my examination/evaluation, performed on _____ (mm-dd-yyyy), I recommend:

☐ Full driving for (select one): ☐ 2 years (max for full-time) ☐ 4 years (max for incidental)

☐ With corrective lenses (check, if applicable)

☐ With hearing aids (check, if applicable)

☐ Driving permitted only for _____ (length of time in months), due to _____ (diagnosis).

Recommend re-evaluation once _____ (employee name) has been effectively managed for a duration of _____ (months/years) and/or stability of condition has been documented by treating provider.

☐ No driving permitted for _____ (length of time in months) due to _____ (diagnosis).

Recommend re-evaluation once _____ (employee name) has been effectively managed for a duration of _____ (months/years) and/or stability of condition has been documented by treating provider.

☐ The individual is not permitted to drive.

☐ More information needed: _____

Name of Provider/Clinician	Signature of Provider/Clinician	Medical Credential/Specialty

Clinic Address/Post	Phone Number	Email

Name of Examinee	DOB

Section V: HU Medical Provider/Clinician Recommendation

(**REQUIRED**, if the above is completed by a local provider)

If the evaluation was performed by a local provider, indicate if your recommendation below:

- ☐ Concur with recommendation above
- ☐ Modify recommendation as follows: _____
- ☐ More information needed: _____

Name of Provider/Clinician	Signature of Provider/Clinician	Medical Credential/Specialty

Clinic Address/Post	Phone Number	Email

Paperwork Reduction Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to 5 CFR 930.108, 339.301 and the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984).

PURPOSE: The information requested on this form will be used to determine medical eligibility for issuance of a driver medical certificate.

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. The information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in denial of a driver medical certification.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.