RISCOM

MEDICAL STATEMENT

Insured's Name:_____	Policy Number:_____
Driver's Full Name:_____	Date of Birth: _____
Driver's Duties:_____	Age:_____
Physician's Name & Address: _____	
Years Under Physician's Care: _____	Date of Last Visit:_____

DRIVER MEDICAL HISTORY – Explain all 'yes' responses in remarks – include question number and explanation.

EYESIGHT

1. HAVE YOU LOST USE/SIGHT OF EITHER EYE? ☐Yes ☐No If yes, please explain: _____
2. IS PERIPHERAL (SIDE) VISION RESTRICTED? ☐Yes ☐No If yes, please explain: _____
3. ARE YOU COLOR BLIND? ☐Yes ☐No If yes, please explain: _____
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS? ☐Yes ☐No If yes, please explain: _____
5. ARE SIGHT DEFICIENCES CORRECTED BY GLASSES/CONTACTS? ☐Yes ☐No If yes, please explain: _____
6. DATE OF LAST EXAMINATION _____

HEARING

7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL? ☐Yes ☐No If yes, please explain: _____
8. IS HEARING AID USED? ☐Yes ☐No If yes, please explain: _____

VISUAL ACUITY

Right Eye: ______Left Eye: ______Both Eyes:_____

HEART

9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE? ☐Yes ☐No If yes, please explain: _____
10. HAVE YOU EVER HAD A HEART ATTACK? ☐Yes ☐No If yes, please explain: _____
11. DO YOU HAVE A PACEMAKER? ☐Yes ☐No If yes, please explain: _____
12. MEDICATION/DOSAGE USED:_____
13. WHEN WAS LAST TREATMENT OR CHECK-UP? _____

LIMBS

14. HAVE YOU LOST AN ARM OR LEG? ☐Yes ☐No If yes, please explain: _____
15. HAVE YOU LOST THE USE OF AN ARM OR LEG? ☐Yes ☐No If yes, please explain: _____
16. DOES CAR HAVE SPECIAL CONTROLS? ☐Yes ☐No If yes, please explain: _____

DIABETES

17. HAVE YOU EVER BEEN TESTED FOR DIABETES? ☐Yes ☐No

A. LATEST BLOOD SUGAR TEST DATE: _____ B. MEDICATION/DOSAGE USED: _____ C. METHOD OF ADMINISTRATION: _____

EPILEPSY

18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY? ☐Yes ☐No

A. IF YES, KIND AND DATE OF LAST SEIZURE:________________ B. MEDICATION/DOSAGE USED: _____

BLOOD PRESSURE

19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE? ☐Yes ☐No

A. IF YES, DATE OF LAST TREATMENT: _____ B. LAST READING: _____ C. MEDICDATION/DOSAGE USED: _____

MISCELLANEOUS

20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM? _____
21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICDATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CERBRAL PALSY, ETC..)? ☐Yes ☐No If yes, please explain: _____
22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE OTHER THAN GLASSES? ☐Yes ☐No If yes, please explain: _____
23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE
    - A. CONVULSIONS: _____
    - B. FAINTING SPELLS _____
    - C. LOSS OF EQUILIBRIUM _____
    - D. ALCOHOL/DRUG ABUSE: _____
    - E. MENTAL/EMOTIONAL ILLNESS: _____
    - F. COMPLETE PHYSICAL EXAMINATION:_____
24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTION ABOVE: _____
25. IS THIS DRIVER FIT TO OPERATE A COMMERCIAL MOTOR VEHICLE? ☐Yes ☐No

PHYSICIAN'S RECOMMENDATION/COMMENTS:

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.

Physician's Signature Date

Driver's Signature Date