Chiropractic Offices of Gonstead, Stangl & Arkowski, LLCs

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DRIVER INFORMATION	
NAME:	BIRTH DATE: ____/____/_____
PHONE: ( ) -	
EMPLOYER INFORMATION	
COMPANY NAME:	CONTACT PERSON:
ADDRESS:	
PHONE: ( ) -	FAX: ( ) -

FINANCIAL RESPONSIBILITY ☐ Company ☐ Employee/Driver
Have you had a DOT medical exam at this office previously? ☐ Yes ☐ No
How did you hear about us? ☐ employer ☐ word of mouth ☐ online ☐ other _____
Would you like a reminder postcard sent to you before your card expires? ☐ Yes ☐ No

NOTICE OF PRIVACY POLICY

We are committed to protecting and maintaining the complete confidentiality of your healthcare information. The federal laws that protect your protected health information (HIPAA) do not provide you with complete privacy. HIPAA allows your healthcare provider to use or disclose your protected health information without further authorization or consent from any number of circumstances, such as:

- In the course of providing healthcare services
- In the event of a referral to another healthcare provider for diagnosis, assessment or treatment
- For insurance and billing purposes
- For internal purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research

You have the right to restrict our ability to use or disclose your protected health information to specific individuals, companies or organizations. If you would like to place a restriction on the use or disclosure of health information, you must inform us in writing.

You have the right to authorize us to disclose protected health information to specific individuals, companies or organizations. If you like to make an authorization we will ask you to complete an authorization form.

You have the right to revoke patient authorization to use or disclose your protected health information time. Your revocation must be in writing.

I acknowledge receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above.

Driver Signature _____ Date _____

I authorize the release of information contained in this DOT medical exam to my employer as listed above. Medical exam failures will automatically and immediately be reported to your employer. After April 2014 results are required reported directly to the CSA.

Driver Signature _____ Date _____

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ◯ M ◯ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

STOP-Bang Questionnaire

Please answer the following questions by checking “yes” or “no” for each one

Snoring – Do you snore loudly? …… □ Yes □ No

Tiredness – Do you often feel tired, fatigued, or sleepy during the daytime?..... □ Yes □ No

Observed Apnea –Has anyone observed that you stop breathing or choke/gasp during your sleep? □ Yes □ No

High Blood **P**ressure – Do you have, or are you being treated for, high blood pressure…….. □ Yes □ No

BMI – Is your body mass index more than 35 kg per m^2? …… □ Yes □ No

Age – Are you older than 50 years? …….. □ Yes □ No

Neck Circumference …… □ Yes □ No

For male – is your shirt collar 17 inches (43 cm) or larger?

For female, is your shirt collar 16 inches (41 cm) or larger?

Gender – are you male? …… □ Yes □ No

Scoring:

Low risk OSA: 0-2

Intermediate risk OSA: 3-4

High risk OSA: 5-8

Or a STOP score ≥ 2 + male gender

Or a STOP score ≥ 2 + BMI > 25 kg/m^2

Or a STOP score ≥ 2 + neck circumference (male >17”/43cm; Female >16”/41cm)

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