MARYLAND DEPARTMENT OF TRANSPORTATION
MOTOR VEHICLE ADMINISTRATION

DC-001(04-19)

Driver Wellness & Safety Division HEALTH QUESTIONNAIRE

INSTRUCTIONS: Please answer each question by checking "Yes" or "No" to all questions as they apply to you. There is space at the end of this questionnaire for your comments and additional information.

This entire form must be completed and returned to the Motor Vehicle Administration, Division of Driver Wellness and Safety, Room 124, 6601 Ritchie Highway, NE, Glen Burnie, MD 21062

Fax 410-582-4936, Email DWSMED@mdot.maryland.gov

SECTION A

Driver License Number		Number of Years Driving	Today's Date
Last Name	First	Middle	Date of Birth

SECTION B

Do you have any of the following conditions (answer each question):

	YES	NO
1. Vison problem, such as blurred or double vision, decreased night vision?	○	○
If yes, explain _____		
2. Diabetes?	○	○
a. Hypoglycemic episode (low blood sugar) in the past year?	○	○
b. Hospitalized due to complications of your blood sugar in past year?	○	○
3. Seizure, epilepsy or condition that caused loss of consciousness or blackout?	○	○
If yes, what is the date of your last episode? _____		
4. Sleep apnea?	○	○
If yes, what treatment are you using? _____		
5. Narcolepsy?	○	○
If yes, what are you using? _____		
6. Heart disease that caused loss of consciousness or blackout in the past year?	○	○
If yes, what was the date(s)? _____		
7. Pacemaker ☐ OR Defibrillator ☐	○	○
8. Stroke or TIA (ministroke)?	○	○
If yes, what was the date(s)? _____		
Did the stroke affect any of the following? ☐Strength ☐Sensation ☐Balance ☐Speech ☐Vision ☐Ability to Walk		
9. TBI (traumatic brain injury)?	○	○
If yes, what was the date? _____		
10. Condition that causes weakness, shaking or numbness in the arms, hands, legs or feet?	○	○
11. Fall in the past 3 years?	○	○
12. Use any of the following to get around? ☐Cane ☐Walker ☐Wheelchair ☐Scooter		
13. Hand, arm, foot or leg that is absent, amputated or has loss of function?	○	○
If yes, what is the date? _____		

Name: _____ **Driver's License Number:** _____

Do you have any of the following conditions (answer each question):

	YES	NO
14.Dementia?	○	○
15.Schizophrenia or a mental condition that may affect your driving?	○	○
16.Use illicit "street "drugs?	○	○

If yes: what drug(s)? _____

What was the date of last use? _____

17.Drink alcohol?	○	○

a. What was the date of your last drink? _____

How many drinks did you have: ☐1 drink ☐2 drinks ☐3 drinks ☐4 drinks ☐5 drinks

18.Take medications?	○	○

If yes, list the medications? _____

_____

_____

19.Any other condition(s) that may affect driving?	○	○

If yes, explain below.

Use the following space for additional information and comments:

_____

_____

_____

_____

SECTION C

I certify that the information I have provided is true and complete to the best of my knowledge and belief.

Driver's Signature	Date	Daytime Phone