## **DOT QUESTIONNAIRE**

PLEASE READ AND COMPLETE ENTIRE FORM. IF <u>1-13</u> APPLY TO YOU, MAKE SURE YOU HAVE THE PROPER DOCUMENTATION READY FOR YOUR APPOINTMENT OR YOU MAY NOT BE ABLE TO DRIVE.

- 1. If you have a history of coronary artery bypass surgery five or more years ago, we will need copies of your normal treadmill results done within the past 12 months.
- 2. If you have had coronary artery stents placed we will need a copy of your normal treadmill done within 3-6 months after the stent or stents were placed.
- 3. If you have had a heart attack, we will need a copy of your normal treadmill that has been done within the last 24 months, a copy of an ECHO since the attack, and official documents showing you are under the care of a cardiologist.
- 4. If you have a history of sleep apnea, we will need your physician's records, done within the past 12 months, showing compliance with the use of your CPAP machine and a normal maintenance of wakefulness or normal multiple sleep latency test also done with the past 12 months.
- 5. If you smoke and are 36 years old or older, or have any of the following: COPD, chronic bronchitis, asthma or emphysema, we will need a copy of your pulmonary function tests (PFTs) done within the past 24 months. Healthy smokers over age 35 still need this test and should bring their results (if these have not been done, have your family doctor order them early enough to have results at the physical).
- 6. If you take Coumadin/warfarin, bring your physician's records showing that you have stable and therapeutic PT/INRs and documentation of your monthly blood tests from the past year. If you take other medications that require levels, (like digoxin, theophylline, lithium) please bring recent official documentation of those levels.
- 7. If you have diabetes mellitus and you're using insulin, bring your Federal waiver, records of your sugars 1 hour before driving, and every 4 hours while driving, yearly logs of all glucose readings, recent reports from your endocrinologist and ophthalmologist, & proof you have emergency glucose tablets.
- 8. If you have had an amputation or partial amputation of any limb we will need to see a copy of your skill performance evaluation certificate.
- 9. If you have any history of serious eye problems like retinopathy, cataracts, macular degeneration or aphakia (the removal of the lens of the eye), we will need a waiver from your ophthalmologist.
- 10. If you have a history of congestive heart failure, we will need a copy of your echocardiogram and Holter monitor both done within the past 12 months, and recent notes from your cardiologist stating you are asymptomatic with no ventricular arrhythmias/irregular heartbeats that are dangerous.
- 11. If you have any heart valve problems we will need a copy of your echocardiogram done within the past 24 months. If you have an aneurysm, bring your physician's records documenting its' size and recommended treatment plans done within the past 12 months.
- 12. Please bring your glasses, contacts, hearing aids, your current driver's license, your old DOT/CDL card, and a list of all your medications.
- 13. If you have a pacemaker, bring proof of functioning from your cardiologist done with the past year.

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PLEASE ANSWER EVERY SINGLE QUESTION!	Yes	No
Do you drink more than 3 caffeinated beverages per day?		
A. Do you snore louder than normal talking or can you be heard through closed doors?		
B. Do often feel tired, fatigued, or sleepy during the day?		
C. Has anyone observed you stop breathing during sleep?		
D. Is your shirt collar size greater than 15-1/2 inches?		
E. Are you presently being treated for hypertension?		
F. Is your gender male?		
Do you drink alcoholic beverages? If yes, how many servings in a typical week? #		
Do you often feel that you need to cut down the amount of alcohol you drink?		
Do you get annoyed when people criticize your alcohol intake?		
Do you feel guilty about how much alcohol you drink?		
Do you drink an alcohol containing beverage as an 'eye opener' in the mornings?		
Do you smoke cigarettes or cigars? If yes, about how many per day? #		
Do you smoke marijuana, or use any other street drugs?		
Have you ever been arrested for drunk or impaired driving, or been treated for alcohol or drug addiction?		
Have you ever attempted suicide or been hospitalized for psychiatric reasons?		
Do you ever feel hopeless or suicidal or do you ever feel like hurting yourself and/or others by crashing your vehicle?		
Do you presently take any medications for psychiatric or nervous disorders or depression?		
Do you ever hear voices or noises that aren't really there, or do you ever see things that aren't really there?		
Do you take any kind of anxiety/nerve pills like: Valium, Xanax, Ativan, clonazepam or alprazolam?		
Do you take narcotics, pain pills, sleeping pills, methadone, or any controlled substances; including stimulants for ADD/ADHD?		
Do you use a hearing aid, wear glasses, or wear contact lenses?		
Do you have a pacemaker, implantable defibrillator, or an artificial heart valve?		

Initials \_\_\_\_\_

PLEASE ANSWER EVERY SINGLE QUESTION!	Yes	No
Have you had a history of epilepsy/seizures or viral encephalitis with seizures within the past 10 years?		
Have you ever had a single solitary seizure that was not treated with medications (with a normal EEG) within the past 5 years?		
Have you ever had a seizure resulting from a head injury in the last 2 years?		
Have you ever had a stroke or bleeding in your brain within the past 5 years?		
Have you ever had a mini stroke, minor leaking blood vessel in the brain, or meningitis within the past 12 months?		
Have you ever been knocked unconscious for more than 30 minutes?		
Have you passed out or nearly passed out within the last 12 months?		
Was this due to low sugar levels?		
Have you ever had a severe penetrating brain injury or any kind of brain surgery?		
Do you have an AV malformation or brain aneurysm that has not been repaired?		
Have you ever had a diagnosis of Parkinson's disease or cerebellar ataxia or dementia?		
Do you have severe frequent headaches that interfere with your driving or affect your vision?		
Do you presently take anticonvulsants or seizure medications?		
Do you take blood thinners/Coumadin, digoxin, lithium, theophylline, or any medication that requires regular lab testing for appropriate levels?		
Have you had surgery within the past 3 months or been hospitalized within the past 5 years?		
Have you ever had a myocardial infarction/ heart attack or any kind of heart problem?		
Have you had a heart attack within the past 2 months?		
Have you ever had a collapsed lung, or any kind of problem with your lungs?		
Do you presently have uncontrolled vertigo, Ménière's disease, labyrinthine fistula, or a nonfunctioning fistula of the inner ear?		
Have you had, within the past 12 months, problems with dizziness?		
What kind of health problems do/did the following family members have/had, and if deceased the approximate age of death and the cause of death?		
A. Mother		
B. Father		
C. Brothers/Sisters		

D. Maternal grandparents \_\_\_\_\_

E. Paternal grandparents \_\_\_\_\_

## PLEASE CIRCLE ANY OF THESE SYMPTOMS THAT APPLY TO YOU

## **Constitutional:** Musculoskeletal: \*Fever/Chills \*Joint pain **Feeling Poorly** \*Muscle pain \*Feeling tired Joint pain Recent weight gain/loss Joint swelling **Night Sweats** Joint stiffness Limb pain/swelling Eyes: Muscle cramps/weakness Eye Pain Red eyes/Discharge Integumentary: \*Vision Changes \*Skin rash Dry Eyes \*Itching Itchy eyes Skin lesions ENT: Change in a mole \*Earache Breast pain/lump \*Sore throat Wound/unusual growth of the skin Nasal Congestion/discharge **Neurological:** \*Headache Nosebleeds Hoarseness \*Dizziness **Hearing loss** Mental changes Cardiovascular: Fainting \*Chest Pain \*Limb weakness Numbness \*Irregular heart beats \*Lower extremity edema Tremor Leg cramps/Pain with exercise Radiating pain Slow heart rate **Psychiatric:** Fast heart rate \*Anxiety Respiratory: \*Depression \*Shortness of breath Suicidal or homicidal thoughts Shortness of breath during exertion Personality changes/irritability Sleep disturbances \*Cough Wheezing **Endocrine:** Shortness of breath with lying down/at night Excessive thirst/urination **Gastrointestinal:** Drooping of eyelid \*Nausea and/or vomiting Hot or cold intolerance \*Abdominal pain Hair loss Generalized weakness \*Diarrhea Heartburn Blood/Lymph: Easy bruising/bleeding Constipation Trouble swallowing Swollen glands Dark or bloody stool **Genitourinary:** \*Pain with urination \*Frequency/urgency of urination **Printed Name** Night time urination Hesitancy Incontinence (loss of urine) Signature Blood in Urine Genital lesion Difficulty with menstrual periods (females) **Date** Erectile Dysfunction (males)