APPENDIX H: FORMS SENT TO DRIVERS BY MARYLAND MAB CASE MANAGER TO COLLECT HEALTH AND MEDICAL INFORMATION

MOTOR VEHICLE ADMINISTRATION Department of Transportation 6601 Ritchie Highway, N. E. Glen Burnie MD 21062	**HEALTH INQUIRY COVER PAGE** Driver Control Division	**Health Inquiry Package** Questions? Please Call: *1-410-768-7361* *TTY For the Deaf 1-800-492-4575*

NOTICE DATE ______________________

DUE DATE FOR ALL FORMS ______________________

The Motor Vehicle Administration has received information that indicates you may have a medical condition that could affect your ability to drive safely. Three forms are enclosed. When properly completed, these forms often allow our Medical Advisory Board (MAB) to make an evaluation about your fitness for driving. These forms are:

1). Medical Advisory Board Health Questionnaire: your medical history and your understanding of your overall situation are most valuable in helping us develop an accurate appreciation of your condition. Your completed questionnaire will be reviewed carefully by at least one MAB doctor. Please be candid; the information you provide will be treated with the professional confidentiality appropriate to any personal medical communication. All MAB doctors and all members of the administrative staff which supports them are bound by their own ethical standards and the Maryland Vehicle Law (paragraph 16-118(d)) to ensure the contents of MAB records are used only to determine qualification to drive and are never disclosed to others. We must use this questionnaire in our review of the great variety of clinical problems evaluated by the MAB - medical, surgical, psychiatric, substance abuse, and so forth; it also may be used in driver safety research projects. Some of the questions might seem unrelated to your situation, but these often turn out to be important for us, so we hope you will be willing to answer all of the questions.

2). Consent for Release of Confidential Information: please provide the name, address, and phone number of both your primary care physician and other doctors or treatment providers who've been involved in your care so we'll be able to contact them if that should become necessary.

3). Physician's Report: we hope your doctor will explain your clinical condition on this form in sufficient detail to enable the MAB to estimate the risk, if there is any, to highway safety. Please fill out Section 1 and then ask your doctor to complete the form and return it to us within two weeks of the date our letter was sent to you. If you and your doctor prefer, you may enclose the completed Physician's Report with the other forms you return to us. If you feel our understanding of your condition will require information from more than one physician, you may reproduce the form enclosed or, you may contact your Case Manager and additional forms will be sent to you.

4). Driver Safety Screening: as part of the review process, we will conduct several Driver Safety Screening tests. Please contact [illegible] at (410) [illegible] who will schedule the screening at one of our MVA full-service offices. Following the screening and review of all medical documentation, you will be further advised.

Please respond promptly. Our commitment to highway safety requires when a driver fails to provide the information requested by the due date, we must render a conservative decision about suspension of the driving privilege. If a suspension is necessary, the right to appeal the decision and the process for doing so will be explained.

CASE MANAGER	DATE	TELEPHONE

6601 Ritchie Highway, N.E.
Glen Burnie, MD 21062
Motor Vehicle Administration

TTY For The Deaf 1-800-492-4575

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

DIVISION OF DRIVER CONTROL
MEDICAL REVIEW SECTION
(410) 768-7361

PLEASE FURNISH COMPLETE NAMES AND ADDRESSES BELOW

NOTICE DATE ______________________

SOUNDEX NUMBER ______________________

DC-5

This Administration is in receipt of information which indicates that you may have a physical, mental, or chemical dependency problem which might affect your ability to safely operate a motor vehicle. We are requesting that you furnish to the Motor Vehicle Administration (MVA) the names of all doctors, hospitals, alcohol and drug clinics, and other programs where you have received treatment or have been monitored and that you execute this authorization for release of medical records and data pertaining to the same.

The purpose for this authorization is to enable the Motor Vehicle Administration to obtain relevant medical data pertaining to its evaluation of your ability to safely operate a motor vehicle. All medical data obtained under this authorization will be kept CONFIDENTIAL and will only be used for those purposes set out in Section 16-118 of the Transportation Article of the Annotated Code of Maryland.

This authorization is to be completed and returned by ______________________

RELEASE FOR MEDICAL INFORMATION

By execution of this authorization, ______________________ gives permission to

PRINTED NAME (Primary Care/Family Practice/Internist)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER
PRINTED NAME (Other treatment facility or program)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER
PRINTED NAME (Other treatment facility or program)	ADDRESS	NATURE OF TREATMENT	TELPEHONE NUMBER
PRINTED NAME (Other treatment facility or program)	ADDRESS	NATURE OF TREATMENT	TELEPHONE NUMBER

to release to the Motor Vehicle Administration all information relative to treatment for a physical, mental, or chemical dependency problem (attendance, treatment, participation, prognosis, rehabilitation).
This authorization will expire on ______________________ .

This authorization may be withdrawn any time except to the extent that information has already been released in reliance thereon.

Signed: ______________________ Date: ______________________

Social Security Number: ______________________ Telephone Number: ______________________

If you are a minor, your parent or legal guardian must sign as a witness.) Witness: ______________________

NOTE: The above-named individual, not MVA, is responsible for any cost incurred as a result of requests made for medical information.

If you have any questions, please contact the Medical Review Section at the above-listed address.

PROHIBITION OF REDISCLOSURE: THIS ADMINISTRATION IS PROHIBITED FROM MAKING ANY FURTHER DISCLOSURES OF INFORMATION FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY THE MARYLAND MOTOR VEHICLE LAW GOVERNING MEDICAL ADVISORY BOARD CASES AND BY FEDERAL LAW, EXCEPT WITH SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY FEDERAL REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

DC-88 (11-98)

Medical Advisory Board
Health Questionnaire

The Medical Advisory Board (MAB) of the Maryland Motor Vehicle Administration has been asked to review your medical status as it relates to driving. A comprehensive medical history is needed for this assessment. Please complete this questionnaire carefully, as instructed below, for our Medical Advisory Board physicians' review.

INSTRUCTIONS

1. Please print all information legibly.
2. Mark the appropriate YES or NO box in the following manner: [X]
3. Use the following format for questions requiring a date: MM / DD / YYYY. For example: 11/26/2000
4. Please answer each question to the best of your ability. Space has been provided on the form for you to write additional information or comments you believe would help us understand your medical condition.
5. All medical information will be kept <u>confidential</u>, as in the traditional doctor/patient relationship, and used only to assess driving safety.
6. At the end of this form you will be asked to certify by your signature that the information you provided is true and complete to the best of your knowledge and belief.

SECTION A

DRIVER LICENSE IDENTIFICATION NUMBER ___-___ ___ ___-___ ___ ___-___ ___ ___-___ ___ ___

SOCIAL SECURITY NUMBER (OPTIONAL) ___ ___ ___-___ ___-___ ___ ___ ___

TODAY'S DATE ___/___/___

LAST NAME | FIRST | MIDDLE | FORMER

DATE OF BIRTH ___/___/___

SEX (Circle) M F

MARITAL STATUS (Circle) SINGLE MARRIED DIVORCED SEPARATED WIDOWED

HEIGHT

WEIGHT

ETHNICITY (OPTIONAL) (Circle) WHITE BLACK HISPANIC ASIAN NATIVE AMERICAN OTHER

EDUCATION (Circle highest grade completed)
1 2 3 4 5 6 7 8 ELEMENTARY
9 10 11 12 HIGH
1 2 3 4 COLLEGE
1 2 3 4 >4 POST GRADUATE

RELIGION PREFERENCE (OPTIONAL) (Circle) Catholic Protestant Jewish Muslim Other None

MILITARY SERVICE (Circle) YES NO

HONORABLE DISCHARGE (Circle) YES NO

SERVICE OUTSIDE USA (Circle) YES NO

DATES OF ACTIVE SERVICE ___/___ – ___/___

HOW MANY YEARS HAVE YOU HAD A DRIVER'S LICENSE?

REASON FOR MEDICAL ADVISORY BOARD REVIEW

LEISURE ACTIVITIES

LIST INTERESTS OR HOBBIES

SECTION B

1. Are you currently (Circle)
   Employed Unemployed Retired Disabled
   1a. If employed, list occupation(s) ______________________
   1b. How long in current position(s)? ______________________
   1c. If unemployed, retired, or disabled list last occupation(s). ______________________

YES NO

2. ☐ ☐ Do you want to remain at your present job?

YES NO

3. ☐ ☐ Are you currently in school?
   If yes (Circle) Full-time Part-time
4. ☐ ☐ Is your current financial situation a problem or are you having an increasing number of financial problems?
5. Annual Income ($)
   ☐ Under 7,500 ☐ 25,000 – 49,999
   ☐ 7,500 – 14,999 ☐ 50,000 – 75,000
   ☐ 15,000 – 24,999 ☐ Over 75,000

Work History (Example cook, plumber, engineer, etc.) Start with most recent job, including military	Length of Time	Check if your current and previous work have involved any of the following.			
		A Chemical or Solvents	B Fumes (metal, welding, chemical)	C Shift Work	D Other Hazardous Substances
1.					
2.					
3.					
4.					

SECTION C

Please complete the chart below. Provide information about you, your spouse and your blood relatives, including those who have died.

Relationship	Please place check mark here if deceased	Current age or age at death if deceased	AIDS	Alcoholism (addiction) or Alcohol Abuse	Anxiety Disorders	Blackouts (fainting, passing out)	Cancer or Leukemia	Congenital abnormality (e.g. blood vessel, bone, muscle)	Dementia, Alzheimer's, memory loss	Depression	Diabetes ("sugar")	Drug Abuse or Drug Addiction	Epilepsy (convulsion, "fits", seizures)	Hypoglycemic Attacks (fainting from low blood sugar)	Kidney Disease	Narcolepsy (falling asleep unpredictably)	Psychotic Disorders (e.g., schizophrenia, manic-depression)	Sleep Apnea	Hearing Loss (deafness) before age 55	Heart Attack/angina (severe chest pain) before age 55	Hypertension (high blood pressure) before age 55	Stroke (brain infarction or hemorrhage) before age 55	Other important conditions? Explain.
You																							
Your spouse																							
Children																							
1																							
2																							
3																							
4																							
Your mother																							
Your mother's mother																							
Your mother's father																							
Your father																							
Your father's mother																							
Your father's father																							
Brothers and sisters																							
1																							
2																							
3																							
Other relatives																							
1																							
2																							
3																							

SECTION D

YES	NO	Have you taken any of the following medications regularly in the last 12 months?
1. ☐	☐	Aspirin-like agents (including Ascriptin, Bufferin, Anacin, or other medicine containing Aspirin).
		1a. If yes, for what purpose? ______
2. ☐	☐	Allergy/asthma medicine (including seasonal)
3. ☐	☐	Blood pressure medicine
4. ☐	☐	Blood thinner (anti-coagulant)
5. ☐	☐	Diuretics (water pills)
6. ☐	☐	Insulin for diabetes
		6a. Date of last blood sugar test ____/____/____
		6b. Test Results: Hgb1c ________ Glucose ________
7. ☐	☐	Oral medicine for diabetes
8. ☐	☐	Medicine for seizures or convulsions
9. ☐	☐	Heart medicine (Nitroglycerin, Inderal, etc.)
10. ☐	☐	Tranquilizers, Anti-anxiety/nerve pills
11. ☐	☐	Lithium
		11a. Date of last blood lithium test ____/____/____
		11b. Test Results ______

YES	NO	
12. ☐	☐	Anti-depressants
13. ☐	☐	Antabuse
14. ☐	☐	Are you allergic to any medications such as penicillin?
		If yes, list ______

15. *List names of all medicines taken regularly (at least once a week). Please check labels on containers.*

15a. ______

15b. ______

15c. ______

15d. ______

16. What surgical operations have you had?

16a. Condition ______

16b. Year ______

16c. Condition ______

16d. Year ______

17. Primary Care Physician ______

17a. Phone Number (______) ______

SECTION E

YES	NO	Have you ever had
1. ☐	☐	Temporary loss of vision in either eye?
2. ☐	☐	Glaucoma (high pressure in the eye)?
3. ☐	☐	Cataracts?
4. ☐	☐	Double vision?
5. ☐	☐	Serious eye injury? Date ____/____/____
6. ☐	☐	Eye surgery? Date ____/____/____
7. ☐	☐	Blindness in either eye?
		7a. Age of onset ______
8. ☐	☐	Loss of side (peripheral) vision?

YES	NO	During the past 12 months have you had
9. ☐	☐	Frequent eye infections or conjunctivitis (pink eye)?
10. ☐	☐	Frequent itching, burning, redness of the eyes, or swelling of the eyelids?
11. ☐	☐	Any unusual difficulty seeing in reduced light (night vision)?
12. ☐	☐	Do you wear eyeglasses/contacts to drive?
		12a. If you wear contact lenses, check ☐ Hard ☐ Soft
13. ☐	☐	Any other eye problems not covered above?
		13a. If yes, please describe ______

SECTION F

YES	NO	Have you ever had
1. ☐	☐	High blood pressure?
2. ☐	☐	Heart trouble, murmur, or rheumatic/scarlet fever?
3. ☐	☐	A heart attack?
		3a. Year(s) ______
4. ☐	☐	Palpitations (pounding, fluttering) of your heart other than when you were upset, excited, or exercising?
5. ☐	☐	A stroke?
		5a. Year(s) ______

YES	NO	
6. ☐	☐	Shortness of breath on mild physical activity (e.g., going up one flight of stairs)?
7. ☐	☐	Breathing difficulty when lying down without a pillow?
8. ☐	☐	Phlebitis (inflamed or sore veins in your legs)?
		8a. Year(s) ______
9. ☐	☐	Tightness, pain, heaviness, squeezing, or pressure around your heart (angina)?
10. ☐	☐	A pacemaker/defibrillator?
		10a. Date implanted ____/____/____

SECTION G

YES	NO	Have you ever had
1. ☐	☐	Epilepsy, convulsions, seizures, or blackout spells?
		1a. Date last attack ____/____/____
		1b. Number of attacks in the past 12 months ______
2. ☐	☐	Weakness in your arms or legs?
3. ☐	☐	Shaking, tremors, or trembling of your hands?
4. ☐	☐	Severe headaches?
5. ☐	☐	A head injury resulting in unconsciousness?
		5a. Date ____/____/____

YES	NO	
6. ☐	☐	Fainting, dizzy spells, or unconsciousness?
7. ☐	☐	Slurred speech or difficulty writing or buttoning your clothes?
8. ☐	☐	Difficulty walking or keeping your balance?
9. ☐	☐	Any other neurologic problems not covered above? If yes, please describe
		9a. Condition ______
		9b. Date of Onset ____/____/____
		9c. Treating Physician ______
		9d. Phone Number (______) ______

SECTION H

	YES	NO	Have you **ever** had
1.	☐	☐	Pain in your neck?
2.	☐	☐	Pain in your upper extremities?
3.	☐	☐	Pain in your lower extremities?
4.	☐	☐	Amputation?
			4a. If yes, what part of body? ____________
5.	☐	☐	Numbness, weakness, or tingling of your fingers, hands, legs?
6.	☐	☐	Pain in your hands, wrists, forearms – particularly when grasping?
7.	☐	☐	Need for a crutch, cane, walker, or wheelchair?
8.	☐	☐	Any other hand or joint problems not covered above?
			8a. If yes, please describe ____________

SECTION I

	YES	NO	
1.	☐	☐	Have you experienced any changes in your mood or feelings that interfere with any of your activities?
2.	☐	☐	Do you have trouble controlling your anger?
3.	☐	☐	Have you ever started a fight where you or someone else got hurt?
4.	☐	☐	Do you have or have you ever had feelings that life is not worth living?
			4a. Date ____ / ____ / _____
5.	☐	☐	Have you ever attempted suicide?
			5a. Date ____ / ____ / _____
			5b. What did you do? ____________
6.	☐	☐	Are you sometimes tense, nervous, anxious, or depressed?
7.	☐	☐	Have you noticed a change in your ability to remember things?
8.	☐	☐	Have you had any recurrent problem(s) sleeping in the last 12 months?
9.	☐	☐	Have you ever been so angry you wanted to kill someone?
10.	☐	☐	Have you received any counseling?
			10a. For what? ____________
			10b. Date Began ____ / ____ / _____
			10c. Date Ended ____ / ____ / _____

SECTION J

	YES	NO	
1.	☐	☐	Do you use alcohol? If yes, check all that apply
			1a. ☐ beer
			1b. ☐ wine
			1c. ☐ liquor
2.			Date of your last drink of alcohol? Date ____ / ____ / _____
3.	☐	☐	Do you use illicit drugs? If yes, do you use them
			3a. ☐ daily
			3b. ☐ weekly
			3c. ☐ occasionally
			3d. ☐ rarely
4.			Date of your last illicit drug use? Date ____ / ____ / _____
5.	☐	☐	Do you usually feel there is a good reason for the occasions when you drink heavily or use drugs?
6.	☐	☐	Did you ever wake up on "the morning after" drinking or using drugs and discover that you could not remember part of the evening before, even though your friends tell you that you did not "pass out"?
7.	☐	☐	Have you noticed an increase in the frequency of your memory "blackouts"?
8.	☐	☐	Are you able to "drink your friends under the table"?
9.	☐	☐	Are you able to handle a larger quantity of drugs now than when you first started to use?
10.	☐	☐	When you are sober, do you sometimes regret things you have said or done while drinking?
11.	☐	☐	Have you tried switching brands or following different plans for controlling your drinking or drug use?
12.	☐	☐	Have you sometimes failed to keep the promises you have made about controlling or cutting down on your drug use?
13.	☐	☐	Do you sometimes feel guilty about your drug use?
14.	☐	☐	Are you irritated when your family or friends discuss your drug use with you?
15.	☐	☐	Have you ever tried to control your drinking or drug use by making a change in jobs or moving to a new location?
16.	☐	☐	Are you having an increasing number of financial problems?
17.	☐	☐	Are you having an increasing number of work problems?
18.	☐	☐	Have you ever had an alcohol-related traffic arrest?
			18a. If yes, number of times? ____________
19.	☐	☐	Do you consider yourself an addicted person, an abuser, or a person with a problem with the use of mood-altering chemicals, including alcohol?
20.	☐	☐	Are you a recovering alcoholic or drug addict?
21.	☐	☐	Have you received treatment for alcohol or drug dependence?
22.	☐	☐	Have you ever had to be detoxified for alcohol or drug use?
			22a. Where? ____________
			22b. Date ____ / ____ / _____
23.	☐	☐	Have you ever been an inpatient for drug or alcohol dependence?
			23a. Where? ____________
			23b. Date ____ / ____ / _____
24.	☐	☐	Have you ever been treated in an outpatient program for drug or alcohol dependence?
			24a. Where? ____________
			24b. Date ____ / ____ / _____
25.	☐	☐	Have you ever heard of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?
26.	☐	☐	Have you ever attended an Alcoholics Anonymous, Narcotics Anonymous, or other type of self-help group meeting?
27.	☐	☐	Have you ever had an AA or NA sponsor?

Directions **Questions 28-37 refer to the last 12 months. Please check the appropriate box**

28. How often do you have a drink containing alcohol?
- [ ] 4 or more times a week
- [ ] 2 to 3 times a week
- [ ] 2 to 4 times a month
- [ ] Monthly or less
- [ ] Never

29. How many drinks containing alcohol do you have on a typical day when you are drinking?
- [ ] 10 or more
- [ ] 7-9
- [ ] 5 or 6
- [ ] 3 or 4
- [ ] 1 or 2

30. How often do you have six or more drinks on one occasion?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

31. How often during the last year have you found that you were not able to stop drinking once you had started?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

32. How often during the last year have you failed to do what was normally expected from you because of drinking?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

33. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

34. How often during the last year have you had a feeling of guilt or remorse after drinking?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

35. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
- [ ] Daily or almost daily
- [ ] Weekly
- [ ] Monthly
- [ ] Less than monthly
- [ ] Never

36. Have you or someone else been injured as a result of your drinking?
- [ ] Yes, during the last year
- [ ] Yes, but not in the last year
- [ ] No

37. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?
- [ ] Yes, during the last year
- [ ] Yes, but not in the last year
- [ ] No

Directions **Questions 38-41 refer to the last 12 months**

38. Have you felt you should cut down on your drinking?
- [ ] Yes
- [ ] No

39. Have people annoyed you by criticizing your drinking?
- [ ] Yes
- [ ] No

40. Have you felt bad or guilty about your drinking?
- [ ] Yes
- [ ] No

41. Have you had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?
- [ ] Yes
- [ ] No

Directions **Questions 42-49a refer to the last 12 months. Please check the appropriate box**

42. Has your use of alcohol sometimes kept you from fulfilling important obligations at work, school, or home?
- [ ] Yes
- [ ] No

43. Have you sometimes used alcohol in potentially hazardous situations, like driving an automobile or a boat, operating machinery, climbing, walking in traffic, using a knife, or swimming?
- [ ] Yes
- [ ] No

44. Have you noticed that you have to use more alcohol than you needed when you first started drinking to get the same effect, or that the same amount of alcohol affects you less than it did earlier?
- [ ] Yes
- [ ] No

45. Have you sometimes used alcohol in larger amounts or over a longer period than you had intended?
- [ ] Yes
- [ ] No

46. Has there been a period of time when you wanted to cut down or control your use of alcohol, or have you made efforts to do so but found you were unsuccessful?
- [ ] Yes
- [ ] No

47. Have you spent a lot of time using alcohol, trying to obtain alcohol, or recovering from the effects of alcohol?
- [ ] Yes
- [ ] No

48. Have you reduced your participation in, or given up, social, occupational, or recreational activities because of alcohol use?
- [ ] Yes
- [ ] No

49. Have you been aware of any physical or psychological problem(s) that is likely to have been caused or made worse by alcohol use?
- ☐ Yes
- ☐ No

49a. If you answered "yes" to Question 49, did you continue to use alcohol after realizing the connection between it and the physical or psychological problem(s)?
- ☐ Yes
- ☐ No

Directions **Questions 50-52a refer to your entire lifetime, not just the last 12 months**

50. Has alcohol ever contributed to social or interpersonal problems in your family, with your friends, with people at work, or at school?
- ☐ Yes
- ☐ No

50a. If you answered "yes" to Question 50, did you continue to use alcohol after becoming aware it was contributing to the problem(s)?
- ☐ Yes
- ☐ No

51. Other than your recent alcohol-related driving offense, has alcohol ever caused any legal problem(s) for you?
- ☐ Yes
- ☐ No

52. If you have ever experienced a problem after stopping or cutting down on your use of alcohol, please place a check beside the applicable symptom(s) in the following list. (Check all that apply)
- ☐ Nervousness or anxiety
- ☐ Agitation
- ☐ Heavy sweating or rapid heartbeat
- ☐ Tremor (shaking) of your hands
- ☐ Difficulty sleeping
- ☐ Nausea or vomiting
- ☐ Seeing, feeling, or hearing things you felt weren't real
- ☐ Having a seizure or epileptic "fit"

52a. Have you ever used alcohol to keep from having any of the symptoms listed in Question 52 or to make them go away?
- ☐ Yes
- ☐ No

SECTION K

For Questions 1-11, please circle T for TRUE and F for FALSE.

Some questions pertain to what you expect to happen when you drink alcohol and should be answered regardless of whether you are currently drinking or not.

		True	False
1.	I smoke or use tobacco products	T	F
2.	I have no problem telling a companion that he/she has done something to hurt my feelings	T	F
3.	I like people who are sharp and witty even though they may sometimes hurt other peoples' feelings.	T	F
4.	I have been arrested for crimes other than drinking and driving	T	F
5.	A family member was arrested for drinking and driving	T	F
6.	I have no trouble sleeping or staying asleep.	T	F
7.	I feel that I have lived the right kind of life.	T	F
8.	I am probably not capable of slapping someone, even when I lose my temper.	T	F
9.	I hardly ever drink more than I plan to.	T	F
10.	I was referred for a liver test, or a blood test for liver enzymes.	T	F
11.	I skipped school as a child	T	F

For Questions 12-15, please answer by writing in your response on the line provided next to each question.

Questions 12 and 13 refer to current drinking habits. If you are no longer drinking then you should reflect that in these questions.

Questions 14 and 15 should be answered according to what you believe would happen if you were drinking.

12. How many days of the week do you usually drink? **If you drink less than once a week put in a 1** ______
13. When you are drinking, how many drinks do you usually have? ______
14. What is the largest number of drinks you ever consumed in a 24-hour period. (One drink = a 12 ounce beer, or a one ounce shot of liquor, or a mixed drink, or a 4 ounce glass of wine, or a 12 ounce wine cooler.) ______
15. How many drinks does it take before you begin to feel the effects of alcohol? ______

SECTION K (Continued)

Listed below are a few statements about your relationships with others.

For Questions 16-18, please circle the number to indicate how much each statement is TRUE or FALSE to you.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
16.	I am always courteous even to people who are disagreeable.	1	2	3	4	5
17.	I sometimes feel resentful when I don't get my way.	1	2	3	4	5
18.	No matter whom I'm talking to, I'm always a good listener.	1	2	3	4	5

SECTION L

YES NO

1. ☐ ☐ Have you ever been arrested for a non-traffic related offense?
   - 1a. If yes, reason ______
   - 1b. Date ___/___/___
   - 1c. If yes, reason ______
   - 1d. Date ___/___/___
2. ☐ ☐ Are you currently on parole or probation?
   - 2a. Reason ______
   - 2b. Expiration Date ___/___/___
3. ☐ ☐ Are you required to see your parole or probation officer? If yes
   - 3a. Name ______
   - 3b. Phone (   ) ______

YES NO

4. ☐ ☐ Have you ever been incarcerated?
   - 4a. For what reason? ______
   - 4b. Dates From ___/___/___ To ___/___/___
   - 4c. For what reason? ______
   - 4d. Dates From ___/___/___ To ___/___/___
5. ☐ ☐ Have you had legal problems related to the use of alcohol or drugs?
6. ☐ ☐ Are you presently in the Drinking Driver Monitoring Program (DDMP)?
   - 6a. Expiration date of monitoring ___/___/___
   - Name and Phone of DDMP monitor
   - 6b. Name ______
   - 6c. Phone (   ) ______

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

______ YOUR SIGNATURE (THIS QUESTIONNAIRE MUST BE SIGNED)

(   ) ______ TELEPHONE NUMBER

___/___/___

OFFICIAL USE ONLY

PROHIBITION ON REDISCLOSURE

This information is confidential and is protected by the Maryland Motor Vehicle Law governing Medical Advisory Board cases and by Federal regulations (42 CFR Part 2) which prohibits anyone from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

______ HX REVIEWED BY

______ DATE

☐ MD ☐ CASE REVIEW ☐ M.R. STAFF

For more information, please call: **1-800-638-8347** (touch tone calls only), **1-800-950-1MVA (1682)** (to speak with a customer service representative), From Out-of-State: **1-301-729-4550**, TDD for the hearing impaired: **1-800-492-4575**. Visit our website at: **www.marylandmva.com**

Motor Vehicle Administration
6601 Ritchie Highway N.E.
Glen Burnie, MD 21062

PHYSICIAN'S REPORT
Division of Driver Control

PHYSICIAN'S REPORT
Questions? Please call:
1-410-768-7361
TTY For the Deaf: 1-800-492-4575

For Office Use Only. Requested By: ________________ **Date Requested** ____________ **Reason:** ____________________

TO THE DRIVER/APPLICANT:

If you are currently being treated by a physician or have been seen by a physician in the last 12 months, please **COMPLETE SECTION 1 (BELOW) ONLY**; then have your physician complete the rest of this form. This PHYSICIAN'S REPORT should be returned to us in the enclosed pre-addressed envelope along with other forms that may be requested in the cover letter that accompanied this form. (Payment for any examination, if necessary, and the preparation of this form is YOUR responsibility.)

ALL medical data obtained will be kept **CONFIDENTIAL** and will be used only to determine your qualifications to drive as set out in Section 16-118 of the Transportation Article of the Annotated Code of Maryland.

SECTION 1: GENERAL INFORMATION (To be completed by driver/applicant)

(Please Type or Print)

DRIVER/APPLICANT'S NAME: ____
(LAST) (FIRST) (MIDDLE)

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH ____________________ PHONE NUMBERS: ____________________
(MO./DAY/YEAR)

DRIVER'S LICENSE NUMBER: ____________ SOCIAL SECURITY NUMBER: ____________

TO THE PHYSICIAN:

Your patient may have a medical or physical condition which requires review by the Medical Review Section and/or Medical Advisory Board. **Please complete this PHYSICIAN'S REPORT** and **return it** to this Administration along with your patient's **completed HEALTH QUESTIONNAIRE** and any other required forms in the envelope provided. Please complete all areas that pertain to your patient. If you have any questions, you may contact the Medical Review Section at the above-listed phone number. **If this information is not returned to our office, as specified in our cover letter to your patient, his/her license/privilege to drive may be subject to suspension.**

(Sections 2 through 8 to be Completed by Physician)

SECTION 2: HISTORY

Have you treated the above-named person or referred him/her to another health care provider for any of the following conditions in the last 2 years? Please clarify any "yes" answers in the **comment** section that follows these questions.

	CIRCLE ONE	DATE
1. Motor Vehicle Accident	YES NO	________
2. Driver's License Revocation, Suspension, Cancellation	YES NO	________
3. Blackout Spells, Dizzy Spells, Epilepsy, Seizures, Loss of Consciousness	YES NO	________

Date of Last Episode ____________________

DC-119 (3-98)

	CIRCLE ONE:	DATE:
4. Other Neurological Impairments	YES NO	____________
5. Head Trauma/Brain Surgery	YES NO	____________
6. Nervousness	YES NO	____________
7. Depression/Confusion/Other Psychiatric Disorders	YES NO	____________
8. Memory Impairment	YES NO	____________
9. Alcoholism	YES NO	____________
10. Visual Impairment/Eye Disease	YES NO	____________
11. Drug Abuse	YES NO	____________
12. Hearing Impairment	YES NO	____________
13. Amputations/Missing Extremities/Prosthesis	YES NO	____________
14. Other Orthopedic Impairments	YES NO	____________
15. High Blood Pressure	YES NO	____________
16. Stroke	YES NO	____________
16. Heart Disease/Cardiovascular Impairments	YES NO	____________
17. Diabetes	YES NO	____________
18. Other Diseases/Ailments/Complications: List Below	YES NO	____________

Comment: (Please type or print)

SECTION 3: PHYSICAL, NEUROLOGICAL AND/OR PSYCHIATRIC EXAMINATIONS

Note POSITIVE Findings Only

1.
2.
3.
4.
5.

Status/level of impairment (e.g. facial droop, paraparesis, ambulatory, wheel chair bound, etc.)

SECTION 4: CURRENT DIAGNOSIS AND MEDICATIONS

LIST CURRENT DIAGNOSIS	CURRENT MEDICATIONS
1.	
2.	
3.	
4.	

SECTION 5: LABORATORY

List positive laboratory results that support diagnosis above [blood count, blood chemistry, EKG, X-ray, etc.]. (Please type or print)

SECTION 6: RESULTS OF TREATMENT TO DATE

1.____ Poor 2.____ Fair 3.____ Good 4.____ Excellent

5. Comment: (Please type or print)

SECTION 7: PROGNOSIS

1.____ Poor 2.____ Fair 3.____ Good 4.____ Excellent

5. **Comment:** (Please type or print)

SECTION 8: PHYSICIAN'S CERTIFICATION

1. Description of Limitation(s) -- include any effect this impairment may have on the patient's ability to safely operate a motor vehicle. (Please type or print)
2. Patient is reliable in taking medications: ____ YES ____ NO
3. Patient's seizures/medical condition is controlled: ____ YES ____ NO
4. Patient has been under my care for: (how long?)
5. In my professional opinion, this person is physically/mentally capable of safely operating a motor vehicle at this time: ____ YES ____ NO
6. **Comment:** (Please type or print)
7. Name of Physician (Print or Type):
8. Physician's Address: ______________________________ Phone No. ____________
9. Physician's License Number: ______________________ 10. Specialty ____________
11. **Physician's Signature:** ______________________ 12. **Date:** ____________