

Last Name: Gleichen First Name: Clark DOB: 12/8/1962 Exam Date: 5/19/2020

DRIVER HEALTH HISTORY (continued)**Do you have or have you ever had:**

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

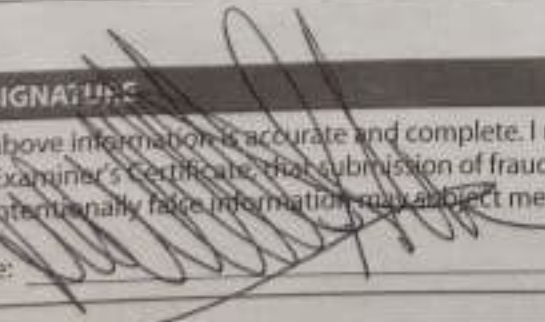
☐ Yes ☐ No ☐ Not Sure

I Broke MY ARM, I Drink ; smoke occasionally

(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: 5/19/2020**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)