

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.

To submit your form electronically, please visit: <https://mymva.maryland.gov/go/web/DocUpload>

Or submit by mail at:

MDOT MVA, Division of Driver Wellness and Safety, Room 124, 6601 Ritchie Highway, NE, Glen Burnie, MD 21062

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. Vision 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? _____

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 arms, hands, legs or feet?.....

11. Fall in the past 3 years?.....

Name:	Driver's License Number
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Do you have any of the following conditions (answer each question):

12. Use of 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 was the date? _____

14. Dementia?.....

15. Schizophrenia or other mental condition that may affect your driving?.....

16. Use illicit "street" drugs?.....

If yes: what drug(s)? _____

What was the last date of use? _____

17. Drink alcohol?.....

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.

Yes

No

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.

Signature _____

Date _____

Daytime Phone _____



Apply to register to vote with your driver's license transaction. For details ask your customer service representative.