Shirley Rolin
Driver Rehab Therapist

FILLABLE FORM

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MEDICAL QUESTIONNAIRE

TYPE OR PRINT NEATLY in black ink

Date DAY MONTH YEAR

1. What is your medical condition/diagnosis?

2. When was this diagnosis made? DAY MONTH YEAR

3. Are you currently being treated for this medical condition? ☐ YES ☐ NO

4. Have you had a seizure in the last 12 months?

☐ NO

☐ YES ▶ Specify the date of the last seizure ▶ DAY MONTH YEAR

5. Do you have a current driver's license or learner's permit that allows you to be evaluated on public streets?

☐ YES ☐ NO ▶ Has it been suspended/revoked or turned away by the Ministry of Transportation Medical Review Section? ▶ ☐ YES ☐ NO

6. Do you currently drive?

☐ YES ▶ How many km per year do you typically drive? ▶

☐ NO ▶ When was the last time you drove? ▶ DAY MONTH YEAR

7. Do you have visual deficits? ☐ YES ☐ NO

If yes, specify

8. Do you have double vision? ☐ YES ☐ NO

9. Do you have any endurance issues that we need to be aware of?

☐ YES ☐ NO

10. Do you have good control of your arms and legs?

☐ YES ☐ NO

11. Do you use a wheelchair or a scooter?

☐ YES ☐ NO

Client's Full Name

E-mail

Address

Phone AREA CODE ( ) NUMBER

Alternative AREA CODE ( ) NUMBER

Signature