TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

PLEASE PROVIDE THIS LETTER TO YOUR PHYSICIAN WITH THE APPLICATION

Dear Healthcare Provider:

The attached form has been brought to you by a candidate for, or current holder of, a Texas Driver's License. This person's case has been referred to the Medical Advisory Board (MAB) by the Texas Department of Public Safety (DPS) because of a concern about the candidate's medical history. The relevant section(s) pertaining to the candidate's referral MUST be completely filled out in order to process the referral. If this is the first time you have seen this patient, please record what the patient states was their last occurrence of the reported medical issue. Also, please state this is the first time you have seen this patient, and this is the information that has been provided to you.

The Health and Safety Code authorizes the MAB to require the person to undergo an examination at his or her own expense. However, at this time we are simply calling for a thorough and current medical evaluation, as it pertains to any medical limitations to driving. Current medical information is defined in our rules as being less than 12 months old. An examination will be necessary if one has not been conducted within 12 months. Please complete and return the MAB Medical History Form to the MAB by the following:

Mail:
Texas Department of State Health Services
ATTN: Medical Advisory Board (MC 1876)
PO Box 149347
Austin, Texas 78714-9909

Email:
dshsmab@dshs.texas.gov

Health and Safety Code, Title 2 Subchapter H, Section 12.098, is the law pertaining to your liability protection, as it concerns any professional opinion, recommendation, or report you make for the purpose of assisting us in determining a candidate's ability to operate a motor vehicle. Please note you are just providing medical information and not an opinion of this person's capability to drive.

If you have any questions about the forms or the procedure, please call (512) 834-6738 or (512) 834-6739.

Medical Advisory Board
Texas Department of State Health Services

MAB MEDICAL HISTORY FORM
To be completed and returned by a licensed healthcare provider

The Texas Department of Public Safety (DPS) has requested that the Medical Advisory Board (MAB) assist them in the evaluation of the case of:

First Name	Middle Name	Last Name

Date of Birth	

Driver's License or Case Number: (Not a State ID Card)	

because of a concern about the candidate's medical history as it pertains to his/her license to operate a motor vehicle. Authority to perform this review is in accordance with the Transportation Code, Chapter 521, Section 321, the Health and Safety Code, Chapter 12, Sections 091 - 098, and the implementing rules adopted by the Texas Department of State Health Services.

Health and Safety Code, Title 2, Subtitle A, Chapter 12, Subchapter H, Medical Advisory Board - Sec. 12.098. Liability.

A member of the medical advisory board, a member of a panel, a person who makes an examination for or on the recommendation of the medical advisory board, or a physician who reports to the medical advisory board or a panel under Section 12.096 is not liable for a professional opinion, recommendation, or report made under this subchapter.
Added by Acts 1995, 74th Leg., Ch. 165, Sec. 9, eff. Sept. 1, 1995.

PATIENT MEDICAL HISTORY

(All sections are **required** to be completed)

I. **Section 1 – Hospitalization (required)**

a. Has the patient been hospitalized within the past two years for problems related to this evaluation?

Yes ☐ (Please provide details below) No ☐ (skip to **Provider History**)

Hospitalization Date:	
Location:	
Reason:	
Physician(s):	

II. **Section 2 - Provider History (required)**

Date of this Exam: ___/___/____
Is this your first time treating this patient? Yes ☐ No ☐
If no, when did you start providing care for this patient? ___/___/____

III. **Section 3 –All Current Medications** (If patient does not take any medications, please write **None** below.)

Name	Dosage	Prescription Date

IV. **Section 4 – Medical Review (REQUIRED)**

Please note the presence of abnormalities in the following applicable sub-section(s). The section indicated in the referral letter **MUST** be fully completed.

a. **Blackout**	Diagnosis
1. Date of blackout	
2. Related to:	
i. Cardiac event (skip to Sub-Section b. Cardiovascular)	
ii. Cognitive impairment (skip to Sub-Section c. Neurological)	
iii. Diabetes (complete Sub-Section d.Metabolic)	
iv. Other	
3. Sleep Apnea	
i. AHI Score	
ii. Test Score	
iii. Equipment use	

b. Cardiovascular	**Diagnosis**
1. Blood pressure	
i. Dyspnea	
ii. Angina	
2. Pacemaker	
i. Date installed	
3. Syncope	
i. Date	

ii. Frequency	
4. Stroke	
5. Functional Capacity	
6. Pulse	
i. Defibrillator	
7. AHA	Class I (mild): No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).
i. Function Capacity (check one)	
☐ Class 1 – No limitation physical activity	
☐ Class 2 – Slight limitation physical activity	
☐ Class 3 – Marked limitation physical activity	
☐ Class 4 – Complete limitation physical activity	☐ Class II (mild): Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in fatigue, palpitation or dyspnea.
ii. Therapeutic Capacities	
☐ Class A – No restrictions	
☐ Class B – Restricted from strenuous activities	
☐ Class C – Slight restriction from normal activity	
☐ Class D – Severe restriction of activity	Class III (moderate): Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes fatigue, palpitation or dyspnea.
☐ Class E – Complete bed rest	
iii. Angina Pectoris: should be characterized by the Canadian Cardiovascular Society classification and heart failure by the New York Heart Association classification.	
☐ Class 0 – Asymptomatic	
☐ Class 1 – Angina with strenuous exercise	

☐ Class 2 – Angina with moderate exertion	☐ Class IV (severe): Unable to carry out any physical activity without discomfort. Symptoms or cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.
☐ Class 3 – Angina with mild exertion	
a. Walking 1-2 level blocks at normal pace	
b. Climbing 1 flight of stairs at normal pace	
☐ Class 4 – Angina at any level of physical exertion	

c. **Neurological**	Diagnosis
1. Date of last seizure	
2. Seizure frequency	
3. Are you concerned that the epilepsy or the anticonvulsants are interfering with cognitive abilities or process speed?	
☐ Yes ☐ No	
4. TIA or function impairment	
5. Recurrent TIAs_____ Function Capacity_____	
6. Hemianopia	
7. Stroke	
8. Dementia	
☐ Yes ☐ No	
9. Cognitive Impairment	
☐ Mild	
☐ Moderate	
☐ Severe	
10. DPS written/driving test recommended	
☐ Yes ☐ No	

d. **Metabolic**	Diagnosis
1. Controlled by medication	
☐ Oral ☐ Insulin	
2. Delivery method	
i. Date begun	

ii. Diabetic control	
☐ Yes ☐ No	
3. ☐ Coma ☐ Shock	
i. Date of last coma/shock	
ii. Frequency	
4. Hypoglycemic incident	
☐ Yes ☐ No	
i. Date of incident	

e. **Mental**	Diagnosis
1. Psychiatric treatment	
i. Hospitalized	
ii. When	
iii. Where	
iv. Judgement	
v. Mental state when form completed (REQUIRED)	
☐ Homicidal	
☐ Assaultive	
☐ Suicidal	
☐ Accident prone	
☐ Impulsive	
☐ Intellectual Disability: IQ_____	
vi. Describe medication side effects subject is experiencing	

f. **Musculoskeletal**	Diagnosis
1. Stiff or flair joints	
i. Where	
2. Spastic or paralyzed muscles	
i. Where	
3. Amputation	
i. Where	

4. Do they use modification(s)?	
☐ Yes ☐ No	
5. Properly trained to use modification?	
☐ Yes ☐ No	
6. Appliances or supports	
i. Where	

g. **Vision**	Diagnosis
1. Acuity	
i. Without correction	
RE 20/_____ LE 20/_____	
ii. With present correction	
RE 20/_____ LE 20/_____	
iii. With best correction	
RE 20/_____ LE 20/_____	
2. If visual acuity is less than 20/30, state cause of visual loss (REQUIRED)	
3. Diplopia	
i. Visual field assessment (Humphrey Method)	
4. Other eye abnormalities	

h. **Alcohol/Drug Use or Abuse**	Diagnosis
1. Number of times treated	
i. When	
ii. Where	
2. Drugs used/abused	
3. Length of dependency	
4. Last know episode of use/abuse (REQUIRED)	
5. Member of Alcoholics/Narcotics Anonymous	

6. Methadone/Antabuse	
i. Dispensing clinic	
7. Urine analysis completed	
i. Date completed	
8. Drug test completed	
i. Date completed	

V. **Section 5 – Additional Information (REQUIRED)**

a. Please provide any additional information or specific comments regarding the patient's medical evaluation:

VI. Healthcare Provider Information (REQUIRED)

Healthcare Provider Signature	
Date	
Name of Healthcare Provider (PRINT)	
State License Number	
Specialty	
Business Address	
City, State, Zip	
Phone Number	