



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:**

Email	Fax	Mail
dshsmab@dshs.texas.gov	(512) 834-6736	Texas Department of State Health Services ATTN: Medical Advisory Board (MC 1876) PO Box 149347 Austin, Texas 78714-9909

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



PLEASE USE THIS COVER SHEET FOR YOUR FAX

FAX TRANSMITTAL

Date: _____

To: Medical Advisory Board
Fax Number: 512-834-6736
Message: Medical forms
Your Name: _____
Driver's License Number: _____
Number of pages after this cover sheet: _____
For any problems or questions, please call (512) 834-6738 or (512) 834-6739

The information contained in this facsimile message may be privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any unauthorized dissemination, distribution, copy, or use of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone. Thank you.

First	Middle	Last	Driver's License #



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

Driver's License Number:	
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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.

First	Middle	Last	Driver's License #



PATIENT MEDICAL HISTORY
(All sections are required to be completed)

I. Section 1 – Hospitalization

- a. Has the patient been hospitalized within the past two years for problems related to this evaluation?
 Yes (Continue to questions below) No (skip to **Section 2**)

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

II. Section 2 – Treatment

Length of time treated:	
Last treated:	
Date of this exam:	

III. Section 3 – Medications

Name	Dosage	Prescription Date

First	Middle	Last	Driver's License #



IV. Section 4 – Medical Review

Please note the presence of abnormalities in the following applicable sub-section(s). If the reason for referral is General Medical, all relevant sections **MUST be completed accordingly.**

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	
i. Function Capacity (check one)	
<input type="checkbox"/> Class 1 – No limitation physical activity	
<input type="checkbox"/> Class 2 – Slight limitation physical activity	

Class I (mild): No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).

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<input type="checkbox"/> Class 3 – Marked limitation physical activity	
<input type="checkbox"/> Class 4 – Complete limitation physical activity	<input type="checkbox"/> Class II (mild): Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in fatigue, palpitation or dyspnea.
ii. Therapeutic Capacities	
<input type="checkbox"/> Class A – No restrictions	
<input type="checkbox"/> Class B – Restricted from strenuous activities	
<input type="checkbox"/> Class C – Slight restriction from normal activity	
<input type="checkbox"/> Class D – Severe restriction of activity	<input type="checkbox"/> Class III (moderate): Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes fatigue, palpitation or dyspnea.
<input type="checkbox"/> 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.	
<input type="checkbox"/> Class 0 – Asymptomatic	
<input type="checkbox"/> Class 1 – Angina with strenuous exercise	
<input type="checkbox"/> Class 2 – Angina with moderate exertion	<input type="checkbox"/> 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.
<input type="checkbox"/> Class 3 – Angina with mild exertion	
a. Walking 1-2 level blocks at normal pace	
b. Climbing 1 flight of stairs at normal pace	
<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. TIA or function impairment	

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5. Recurrent TIAs _____ Function Capacity _____	
6. Hemianopia	
7. Stroke	
8. Dementia	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Cognitive Impairment	
<input type="checkbox"/> Mild	
<input type="checkbox"/> Moderate	
<input type="checkbox"/> Severe	
10. DPS written/driving test recommended	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

d. Metabolic	Diagnosis
1. Controlled by medication	
<input type="checkbox"/> Oral <input type="checkbox"/> Insulin	
2. Delivery method	
i. Date begun	
ii. Diabetic control	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. <input type="checkbox"/> Coma <input type="checkbox"/> Shock	
i. Date of last coma/shock	
ii. Frequency	
4. Hypoglycemic incident	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Date of incident	

e. Mental	Diagnosis
1. Psychiatric treatment	
i. Hospitalized	
ii. When	
iii. Where	
iv. Judgement	
v. Mental state at time form filled	
<input type="checkbox"/> Homicidal	
<input type="checkbox"/> Assaultive	
<input type="checkbox"/> Suicidal	
<input type="checkbox"/> Accident prone	
<input type="checkbox"/> Impulsive	
<input type="checkbox"/> Mental retardation: IQ _____	

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vi. Describe medication side effects subject is experiencing	
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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)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Properly trained to use modification?	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	
3. Diplopia	
i. Visual field loss	
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	

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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:

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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	

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