ACORD. MEDICAL STATE	ΞΜΙ	ENT									DATE (MI	//DD/YY)	
PRODUCER			ME AND MAIL	ING ADDR	ESS (Incl	lude co	ounty & ZII	P)					
									_				
		ТЕ							ELEPHONE NUMBER				
		/PLAN											
		/FLAN				POL							
CODE: SUBCODE: AGENCY CUSTOMER ID		ACCT#:						PAYMENT PL	YMENT PLAN				
		RNWL					AGENCY BIL						
DRIVER INFORMATION													
DRIVER'S NAME		DATE C	F BIRTH	AGE	SE	xc	OCCUPATI	ON					
EMPLOYER'S NAME AND ADDRESS		-AMILY PHY	SICIAN'S NAM	IE AND AL	DRESS					YRS UNDER PHYSICIAN CARE	ER DATE OF LAST VISIT		
										CARE			
DRIVER MEDICAL HISTORY													
EXPLAIN ALL "YES" RESI	PONSES	5 IN REMAR	KS - INCLUDE	QUESTIO	N NUMBE	ER AND	D EXPLAN	ATION					
	YES	NO									YES	NO	
EYESIGHT			EPILEP	SY									
1. HAVE YOU LOST USE/SIGHT OF EITHER EYE?		18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY?											
2. IS PERIPHERAL (SIDE) VISION RESTRICTED?		A. IF YES, KIND AND DATE OF LAST SEIZURE:								-			
3. ARE YOU COLOR BLIND?		B. MEDICATION/DOSAGE USED:											
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS? 5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS?		BLOOD PRESSURE 19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE'											
6. DATE OF LAST EXAMINATION:							REATMEN			NESSONE!			
HEARING			_	LAST REA				••		-			
7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL?			C.	MEDICAT	ION/DOS/	AGE U	SED:						
8. IS HEARING AID USED?			MICOL										
HEART				.LANEOUS		EN TRE	ATED OR	RECEIV	ED MEDI	CATION			
9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE?		FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM?							ROBLEM?				
10. HAVE YOU EVER HAD A HEART ATTACK?		21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPH											
11. DO YOU HAVE A PACEMAKER? 12. MEDICATION/DOSAGE USED:							REBRAL P			ISTROPHT,			
13. WHEN WAS LAST TREATMENT OR CHECK-UP?				E THERE			IONS POS	STED ON	YOUR D	RIVERS			
LIMBS			_				REATMEN	T, IF APP	LICABLE				
14. HAVE YOU LOST AN ARM OR LEG?		A. CONVULSIONS:							_				
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG?		B. FAINTING SPELLS:							_				
16. DOES CAR HAVE SPECIAL CONTROLS?		C. LOSS OF EQUILIBRIUM:						_					
DIABETES		D. ALCOHOL/DRUG ABUSE:						_					
17. HAVE YOU EVER BEEN TESTED FOR DIABETES?				MENTAL/E						_			
A. LATEST BLOOD SUGAR TEST DATE:			_ F.	COMPLET	E PHYSIC	CAL EX	KAMINATIO	ON:		-			
B. MEDICATION/DOSAGE USED: C. METHOD OF ADMINISTRATION:							E OF A PH ED ABOVE		FOR AN	Y			
			_ 00										
REMARKS													
I DECLARE THAT TO THE BEST OF MY KN	IOWL	EDGE A	ND BELIE		OF THE	FOF	REGOIN	IG STA	TEME	NTS ARE	FRUE.		
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