# Welcome to the ACCESS OMNICARE – Commercial Driver Medical Exam

***Your Occupational Medicine partner in Health and Safety***

**Please complete this document and return it with your Driver's License**

| LAST NAME: | FIRST NAME: | MIDDLE NAME: | PREFERRED NAME: |
|---|---|---|---|
| | | | |

| SEX: GENDER | DATE OF BIRTH: | SOCIAL SECURITY NUMBER: | FORMER LAST NAME: |
|---|---|---|---|
| ◯ MALE ◯ FEMALE | | | |

| ADDRESS: | APARTMENT #: | ZIP CODE: | CITY: |
|---|---|---|---|
| | | | |

| STATE: | HOME PHONE: | MOBILE PHONE: | WORK PHONE: |
|---|---|---|---|
| | | | |

| EMAIL ADDRESS: Used for appointment updates | HOW SHOULD WE CONTACT YOU? |
|---|---|
| | ◯ HOME PHONE ◯ WORK PHONE ◯ CELL PHONE ◯ EMAIL |

| PREFERRED LANGUAGE: | RACE: | MARITAL STATUS: |
|---|---|---|
| | | ◯ MARRIED ◯ SINGLE ◯ DIVORDED ◯ PARTNERED |

| EMERGENCY CONTACT NAME: | RELATIONSHIP: | HOME PHONE: | CELL PHONE: |
|---|---|---|---|
| | | | |

| EMPLOYER or COMPANY NAME |
|---|
| |

| EMPLOYER'S ADDRESS: | CITY: | STATE: | ZIP CODE: |
|---|---|---|---|
| | | | |

| EMPLOYER PHONE: | OCCUPATION: | EMPLOYER CONTACT: | YEARS OF EMPLOYMENT: |
|---|---|---|---|
| | | | |

**Medical Services:**

☐ DOT EXAM – INITIAL CERTIFICATION
☐ DOT EXAM – RECERTIFICATION
☐ DOT EXAM – FOLLOW UP EXAMINATION

**LAST** CERTIFICATION: ☐ 3 MO ☐ 6 MO ☐ 1 YR ☐ 2 YR
**LAST** CERTIFICATION BY: _____

**Medication and History Review:**

| ALLERGIES: | ◯ No Known Allergies | LATEX ALLERGY: | ◯ YES ◯ NO |
|---|---|---|---|

| CURRENT MEDICATIONS: | ◯ See attached list |
|---|---|

**Medication Review – Have you been prescribed any of the following medications?**

☐ MEDICATON FOR PAIN _____
☐ MUSCLE RELAXANTS _____
☐ SEDATIVES _____
☐ INSULIN FOR DIABETES _____
☐ BLOOD THINNERS _____
☐ ANTI-DEPRESSANTS _____
☐ ANTI-ANXIETY MEDICATION _____
☐ ANTI-SEIZURE MEDICATION _____

**FOR CLINIC USE ONLY**

Ht_____ Wt_____ BP_____ / _____ Pulse _____ O2 _____ RR _____ Temp _____ Pain _____ LMP: _____

**Urinalysis:** Leuk _____ Nit _____ Urobili _____ Protein _____ pH _____ Blood _____ Spec Grav _____ Ketone ____ Bili ____ Glucose _____

**Vision:** Distance **Uncorrected**: **R** 20/____ **L** 20/____ Near **Uncorrected**: **R** 20/____ **L** 20/____
Distance **Corrected**: **R** 20/____ **L** 20/____ Near **Corrected**: **R** 20/____ **L** 20/____ ☐ Glasses ☐ Contacts

**Ishihara:** ☐ Normal ☐ Abnormal Gross Hearing intact (forced whisper): ☐ RIGHT ☐ LEFT **Treating MA:** _____ Room: _____

CHECK IN: [ ] READY MA: [ ] VITALS: [ ] READY DOC: [ ] CHECK OUT: [ ]

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## Medical History Review: Please check <u>each item</u> YES or NO

| DO YOU HAVE ANY OF THE NATIONS MOST COMMON MEDICAL CONDITIONS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **YES** | **NO** | **Date/Year Diagnosed** | **PAST MEDICAL HISTORY** | **PAST MEDICAL HISTORY** | **YES** | **NO** | **Date/Year Diagnosed** |
| | | | Hypertension – Elevated Blood Pressure | Aortic stenosis | | | |
| | | | High Cholesterol or Lipids | Mitral valve regurgitation | | | |
| | | | Diabetes - treated with oral medications | Heart valve replacement | | | |
| | | | Diabetes - treated with insulin | Pacemaker | | | |
| | | | Hypothyroidism | Arrhythmia or irregular heart rate | | | |
| | | | Thyroid Problems | Atrial fibrillation | | | |
| | | | Hearing Loss | Abdominal aortic aneurysm (AAA) | | | |
| | | | Mental Illness | Thoracic aneurysm | | | |
| | | | Menier's Disease | Taking anticoagulants such as | | | |
| | | | Vertigo | Deep Vein Thrombosis (DVT) | | | |
| | | | Labyrinthine Fistula | Pulmonary embolism (PE) | | | |
| | | | Syncope | Superficial Phlebitis | | | |
| | | | Stroke | Varicose Veins | | | |
| | | | Transient Ischemic Attack or TIA | Claudication or leg pains | | | |
| | | | Traumatic Brain Injury | Restless leg syndrome | | | |
| | | | Brain hemorrhage | Allergies - environmental | | | |
| | | | Seizure disorder or Epilepsy | Chronic Obstructive Pulmonary | | | |
| | | | Headaches | Congestive Heart Failure (CHF) | | | |
| | | | Neuropathy or Peripheral neuropathy | Coronary Artery Disease – Heart | | | |
| | | | Muscular weakness | Lung Disease | | | |
| | | | Muscular Dystrophy | Tuberculosis | | | |
| | | | Dementia | Asthma | | | |
| | | | Heart attack or Myocardial Infarction | Sleep disorder | | | |
| | | | Angina | Sleep apnea | | | |
| | | | Coronary Artery Bypass Graft (CABG | Chest wall deformity | | | |
| | | | Heart procedure such as angioplasty | Cystic fibrosis | | | |
| | | | Heart transplant | Interstitial lung disease | | | |
| | | | Aortic regurgitation | Pulmonary Hypertension | | | |
| | | | Heart valve disease | Other Conditions – to be discussed | | | |

## G. Certification History – Please answer the questions below

1. Have you ever had a restriction on your commercial driving license? ☐ YES ☐ NO
2. Have you ever been diagnosed with Stage 3 Hypertension – Blood pressure = or > 180/110? ☐ YES ☐ NO
3. Do you currently have a driving Waiver or Exemption? ☐ YES ☐ NO
4. Are you required to wear corrective lenses when driving? ☐ YES ☐ NO
5. Are you required to have a hearing aid when driving? ☐ YES ☐ NO

**Explain any YES answers below:**

# CONSENT FOR EVALUATION AND TREATMENT

Authorization for Medical Services

I consent to medical treatment from Access Omnicare ("AOC"), its affiliates, physicians, and employees. Treatment may include any necessary examination, test, or medical procedures ordered by the medical providers to be performed by AOC staff. I understand I may refuse treatment at any time. If I am seeking nonregulated substance abuse testing, I authorize AOC to obtain a specimen of my urine, blood, saliva, breath, hair, or other specimen to determine the presence of drugs or alcohol. I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of my personal physician.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I have reviewed or have been given an opportunity to review the AOC Notice of Privacy Practices (NPP). I have had an opportunity to ask questions about it and received satisfactory answers. I may ask for a copy of the NPP or can view it electronically at http://www.accessomnicare.com

- If I am being treated as an urgent care patient for a non-work-related injury and I have health insurance, I assign to AOC all payments under the terms of my applicable insurance policies.
- If I am being treated as an urgent care patient for a non-work-related injury and I do not have health insurance, I understand I am responsible for payment. I have a right to ask for the charge amounts before electing treatment.
- If I am treated for a workers' compensation injury or illness, AOC will seek payment from the responsible payer, which is typically the employer or the employer's workers' compensation insurance carrier.
- If I am receiving employer-directed services (e.g. drug testing, physicals, medical surveillance) AOC will seek payment from the employer. I may be responsible for payment if allowed by State or Federal law.
- If I am responsible for payment and my account is referred to collections, I understand that I may have to pay collection expenses incurred by AOC.

By signing this form, I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given the opportunity to ask questions, and any questions have been answered satisfactorily.

**Patient signature confirming:**

Print Name: _____ Signature: _____ Date: _____

**Spouse/Parent/Guardian/Conservator signature confirming:**

Print Name: _____ Signature: _____ Date: _____

# AUTHORIZATION TO DISCLOSE
# Protected Health Information to Employer

My employer or potential employer has sent me to Access Omnicare ("AOC") for testing, evaluation, or treatment. By signing below, I authorize AOC to disclose my protected health information in accordance with the following terms and conditions:

1. **REQUIRED**: Name of current or prospective employer _____.

2. If I have been sent to AOC for only a drug screen, my protected health information only includes the results of that drug screen. Otherwise, my protected health information can include the results of tests or evaluations, including diagnoses and medical history relevant to the tests and evaluations performed that my employer or prospective employer has ordered or requires.

3. AOC may disclose my protected health information to my employer, prospective employer, or to an entity designated to evaluate my suitability for (1) initial or continued employment or (2) other activity required by my employer, or any other disclosure required by law.

4. I understand that my health information may not be protected from further disclosure by some entities receiving my information under this authorization, and that AOC has no control over subsequent disclosures by other entities.

**MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION**

- This authorization will expire one year from the date of when I am no longer employed by the above named employer or one year from the date below, whichever is later.

- I can ask for a copy of the protected health information that will be disclosed. A processing and/or copying charge may apply as permitted by law.

- My treatment may not be conditioned on my signing of this authorization unless the sole purpose of my visit to AOC is for my employer or prospective employer to obtain health information about me.

- I have a right to not sign this authorization or to limit the information I authorize to be disclosed. However, refusal to sign this authorization may violate a condition of employment or prospective employment. Contact your employer for details.

- I may revoke this authorization at any time, but I must do so in writing to the clinic where I received services. My revocation will not apply to disclosures that have already occurred under this authorization. Revocation of this authorization may carry consequences related to my employment or prospective employment. Contact your employer for details.

- I have a right to receive a copy of this authorization.

By signing this form I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

**Patient signature confirming:**

Print Name: _____ Signature: _____ Date: _____