

DRIVER HEALTH QUESTIONNAIRE

PLEASE HAVE THIS COMPLETED BY ALL DRIVERS OVER THE AGE OF 75

NAMED OF INSURED _____

POLICY NUMBER _____

DRIVER INFORMATION

1. YOUR NAME _____
2. DATE OF BIRTH _____
3. HOW LONG HAVE YOU BEEN DRIVING? _____
4. DATE OF LAST LICENSE EXAMINATION _____
5. LIST MOVING TRAFFIC VIOLATIONS AND ACCIDENTS DURING THE PAST 3 YEARS

6. DO YOU HAVE A RESTRICTED LICENSE, OTHER THAN CORRECTIVE LENSES? NO YES
IF YES, DESCRIBE RESTRICTION. _____

7. HAS THE AUTOMOBILE BEEN ALTERED TO COMPENSATE FOR ANY IMPAIRMENT?
(HAND CONTROLS, GAS PEDAL MOVED, ETC.). IF YES, EXPLAIN. _____

8. DO YOU PRACTICE ANY SELF-IMPOSED RESTRICTIONS ON YOUR DRIVING? NO YES
IF YES, EXPLAIN _____

MEDICAL INFORMATION- PLEASE EXPLAIN ALL YES ANSWERS IN THE REMARKS SECTION

9. DO YOU OR ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING?
 - A. DIZZY OR FAINTING SPELLS NO YES
 - B. DIABETES NO YES
 - C. EPILEPSY NO YES
 - D. HIGH BLOOD PRESSURE NO YES
 - E. HEART ATTACK OR STROKE NO YES
10. HAVE YOU BEEN ADVISED BY A PHYSICIAN TO RESTRICT YOUR DRIVING
ACTIVITIES? NO YES
11. ARE YOU TAKING MEDICATION, WHICH MIGHT AFFECT YOUR DRIVING? NO YES
12. DO YOU HAVE ANY IMPAIRMENT OF EYESIGHT OR HEARING? NO YES
13. WHAT IS THE APPROXIMATE DATE OF YOUR LAST EYE EXAM?

14. WHAT WAS YOUR LAST ACUITY RATING? LEFT 20/____ RIGHT 20/____

REMARKS

SIGNATURE OF DRIVER _____ DATE _____