La Grange | Flatonia | Giddings
Family Health Centers

William Michael McBroom, M.D. Thomas O. Borgstedte, D.O. Wess J. Blackwell, M.D.

La Grange	Flatonia	Giddings
O: (979) 968-8493	O: (361) 865-3302	O: (979)542-7400
F: (979) 968-6388	F: (361) 865-3631	F: (979) 542-3031
1253 N Von Minden	230 W North Main	598 Cactus St
La Grange, TX 78945	Flatonia, TX 78941	Giddings, TX 78942

DOT PACKET

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	☐ MALE ☐ FEMALE
PREFERRED CONTACT: ☐ CELL ☐ HOME ☐ WORK	#:	#:
EMAIL:	SSN:	DRIVERS LIC:
ADDRESS: CITY:	STATE:	ZIP CODE:
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	RACE: ☐ CAUCASIAN/WHITE ☐ AFRICAN AMERICAN/BLACK ☐ HISPANIC ☐ ASIAN ☐ OTHER	

GUARANTOR INFORMATION (SKIP IF THE PATIENT IS THE GUARANTOR)

GUARANTOR NAME:		DATE OF BIRTH:	
MAILING ADDRESS:	CITY:	STATE:	ZIP:
RELATIONSHIP TO PATIENT:	SSN:		
CELL#:	HOME#:	ALT#:	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:
SECONDARY INSURANCE COMPANY:		
GROUP #:	POLICY #:	
POLICY HOLDER:	DATE OF BIRTH:	SSN:

EMERGENCY CONTACT

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

**Family Health Center files insurance as a courtesy to our patients. It is the sole responsibility of the patient/guarantor to verify that the Provider and/or service they receive here are covered by their insurance/payor. Payment is due at the time services are rendered including any copay/coinsurance/deductible portions.

I, ______________________________ (Self/Guardian/Guarantor) have read the following material; Office, Insurance, and Payment Policy and the Notice of Privacy Practices, presented to me by Family Health Center and I understand my responsibilities as the Patient/Guardian/Guarantor of this facility and that all of the information provided on this form is true and correct.

SIGNATURE: ______________________________ Date: ______________________

PRINT NAME: ______________________________ Relationship if not self: ______________

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PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:	TODAY'S DATE:

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Domestic Partner | □ MALE □ FEMALE

OCCUPATION:	NUMBER OF CHILDREN:	NUMBER OF SEXUAL PARTNER:	CONTRACEPTIVE METHOD USE:

HEALTH HABITS:

TOBACCO	ALCOHOL	EXERCISE:	DIET
□ Do not use tobacco □ Cigarettes: ___ pks/day for ___ years □ Cigars/Pipe □ Dip/Chew □ Electronic Cig/Vape □ I would like to quit	□ Do not drink □ Beer: ___ bottles/day □ Wine: ___ drinks/day □ Alcohol: ___ drinks/day □ I would like to quit	□ Exercise Daily □ Exercise Regularly □ Rarely Exercise □ Never Exercise	□ Overweight □ Desired Weight □ Special Diet

SELF MEDICAL HISTORY: CHECK ALL THAT APPLY

ADHD		Depression		GERD		Alcoholism	
Anemia		High Cholesterol		Heart Disease		Osteoporosis	
Anxiety		Headaches/Migraines		Hepatitis/Liver Disease		Seizure Disorder	
Asthma		COPD		Hypertension		Stroke	
Diabetes		Bleeding Disorders		Tuberculosis		Thyroid Disease	
Cancer		What kind?		When?		Other:	

Have you been in the past 12 months or are you currently under the care of another healthcare professional? If yes, please list below:

FAMILY MEDICAL HISTORY: CHECK ALL THAT APPLY AND LIST FAMILY MEMBERS

M: Mother **MGM**: Maternal Grandmother **PGM**: Paternal Grandmother **PA**: Paternal Aunt **MA**: Maternal Aunt **S**: SIBLING
F: Father **MGF**: Maternal Grandfather **PGF**: Paternal Grandfather **PU**: Paternal Uncle **MU**: Maternal Uncle

ADHD		Asthma		Diabetes		Heart Disease	
Alcoholism		Depression		High Cholesterol		Seizure Disorder	
Alzheimer's Disease		Arthritis		Anxiety		Hypertension	
COPD		Cancer:		What Kind?		Other:	

ALLERGIES:	
NAME OF MEDICATION/FOOD:	REACTION:

ALL MEDICATION(S) YOU ARE CURRENTLY TAKING:		
NAME OF MEDICATION:	DOSAGE OF MEDICATION:	PROVIDER THAT PRESCRIBED MED:
PHARMACY YOU ARE CURRENTLY USING:		

SURGERY HISTORY		
DATE:	SURGERY/HOSPITALIZATION/MAJOR ILLNESS:	WHERE:

WOMEN ONLY:		
Number of Pregnancies:	Number of Miscarriages/Abortions:	Number of Live Children:
Date of last pap smear:	Result:	Date of last mammogram:
Perform breast self-exam? □ Yes □ No	Period: □ Regular □ Irregular	Menopausal? □ Yes □ No
Method of Birth Control: □ None □ Pills □ Condom □ Sponge □ Foam □ Norplant □ IUD □ Diaphragm □ Rhythm □ Tubal Ligation □ Vasectomy □ Other		

Copy

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: ______________ First Name: ______________ Middle Initial: ___ Date of Birth: ______________ Age: ___

Street Address: ______________ City: ______________ State/Province: ___ Zip Code: ______

Driver's License Number: ______________ Issuing State/Province: ______________ Phone: ______

E-Mail *(optional)*: ______________ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: ______________

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: ____________ First Name: ____________ DOB: ____________ Exam Date: ____________

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	O	O	O
2. Seizures/epilepsy	O	O	O
3. Eye problems *(except glasses or contacts)*	O	O	O
4. Ear and/or hearing problems	O	O	O
5. Heart disease, heart attack, bypass, or other heart problems	O	O	O
6. Pacemaker, stents, implantable devices, or other heart procedures	O	O	O
7. High blood pressure	O	O	O
8. High cholesterol	O	O	O
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	O	O	O
10. Lung disease *(e.g., asthma)*	O	O	O
11. Kidney problems, kidney stones, or pain/problems with urination	O	O	O
12. Stomach, liver, or digestive problems	O	O	O
13. Diabetes or blood sugar problems	O	O	O
Insulin used	O	O	O
14. Anxiety, depression, nervousness, other mental health problems	O	O	O
15. Fainting or passing out	O	O	O
16. Dizziness, headaches, numbness, tingling, or memory loss	O	O	O
17. Unexplained weight loss	O	O	O
18. Stroke, mini-stroke (TIA), paralysis, or weakness	O	O	O
19. Missing or limited use of arm, hand, finger, leg, foot, toe	O	O	O
20. Neck or back problems	O	O	O
21. Bone, muscle, joint, or nerve problems	O	O	O
22. Blood clots or bleeding problems	O	O	O
23. Cancer	O	O	O
24. Chronic (long-term) infection or other chronic diseases	O	O	O
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	O	O	O
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	O	O	O
27. Have you ever spent a night in the hospital?	O	O	O
28. Have you ever had a broken bone?	O	O	O
29. Have you ever used or do you now use tobacco?	O	O	O
30. Do you currently drink alcohol?	O	O	O
31. Have you used an illegal substance within the past two years?	O	O	O
32. Have you ever failed a drug test or been dependent on an illegal substance?	O	O	O

Other health condition(s) not described above: O **Yes** O **No** O **Not Sure**

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: O **Yes** O **No** O **Not Sure**

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: ____________ Date: ____________

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: ____________ First Name: ____________ DOB: ____________ Exam Date: ____________

TESTING

Pulse Rate: ________ Pulse rhythm regular: ○ Yes ○ No

Height: ___ *feet* ___ *inches* Weight: ____ *pounds*

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

Other testing if indicated

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.				

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/____	Right Eye: ____ degrees
Left Eye:	20/____	20/____	Left Eye: ____ degrees
Both Eyes:	20/____	20/____	

	Yes	**No**
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	○	○
Monocular vision	○	○
Referred to ophthalmologist or optometrist?	○	○
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet ***OR*** *average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☐ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	______	______

OR

Audiometric Test Results

Right Ear: 500 Hz	1000 Hz	2000 Hz	Left Ear: 500 Hz	1000 Hz	2000 Hz
______	______	______	______	______	______

Average (right): ____________ Average (left): ____________

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	**Body System**	Normal	Abnormal
1. General	○	○	8. Abdomen	○	○
2. Skin	○	○	9. Genito-urinary system including hernias	○	○
3. Eyes	○	○	10. Back/spine	○	○
4. Ears	○	○	11. Extremities/joints	○	○
5. Mouth/throat	○	○	12. Neurological system including reflexes	○	○
6. Cardiovascular	○	○	13. Gait	○	○
7. Lungs/chest	○	○	14. Vascular system	○	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: ____ First Name: ____ DOB: ____ Exam Date: ____

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

○ Does not meet standards *(specify reason)*: ____

○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

○ Meets standards, but periodic monitoring required *(specify reason)*: ____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: ____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: ____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*

☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*

○ Determination pending *(specify reason)*: ____

☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: ____

☐ Medical Examination Report amended *(specify reason)*: ____

(if amended) Medical Examiner's Signature: ____ Date: ____

○ Incomplete examination *(specify reason)*: ____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: ____

Medical Examiner's Name *(please print or type)*: Wildon Rouse PA-C

Medical Examiner's Address: 1253 N Von Minden St City: La Grange State: TX Zip Code: 78945

Medical Examiner's Telephone Number: (979) 968-8493 Date Certificate Signed: ____

Medical Examiner's State License, Certificate, or Registration Number: PA02598 Issuing State: TX

☐ MD ☐ DO ☑ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: ____

National Registry Number: 2367887770

Medical Examiner's Certificate Expiration Date: ____

Last Name: ______ First Name: ______ DOB: ______ Exam Date: ______

MEDICAL EXAMINER DETERMINATION (State)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations):

○ Does not meet standards in 49 CFR 391.41 with any applicable State variances *(specify reason)*: ______

○ Meets standards in 49 CFR 391.41 with any applicable State variances

○ Meets standards, but periodic monitoring required *(specify reason)*: ______

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: ______

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: ______

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

If the driver meets the standards outlined in 49 CFR 391.41, with applicable State variances, then complete a Medical Examiner's Certificate, as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: ______

Medical Examiner's Name *(please print or type)*: Wildon Rouse PA-C

Medical Examiner's Address: 1253 N Von Minden St City: La Grange State: TX Zip Code: 78945

Medical Examiner's Telephone Number: (979) 968-8493 Date Certificate Signed: ______

Medical Examiner's State License, Certificate, or Registration Number: PA02598 Issuing State: TX

☐ MD ☐ DO ☑ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: ______

National Registry Number: 2367887770

Medical Examiner's Certificate Expiration Date: ______

Form MCSA-5876

OMB No.: 2126-0006 Expiration Date: 12/31/2024

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U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** ______ **First Name:** ______ in accordance with *(please check only one)*:

○ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)* ***OR***

○ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)*:

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a ______ waiver/exemption
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
- ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*
- ☐ Grandfathered from State requirements *(State)*

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date ______

Medical Examiner's Signature ______

Medical Examiner's Telephone Number
(979) 968-8493

Date Certificate Signed ______

Medical Examiner's Name *(please print or type)*
Wildon Rouse PA-C

○ MD ◉ Physician Assistant ○ Advanced Practice Nurse
○ DO ○ Chiropractor ○ Other Practitioner *(specify)* ______

Medical Examiner's State License, Certificate, or Registration Number
PA02598

Issuing State
Texas

National Registry Number
2367887770

Driver's Signature ______

Driver's License Number ______

Issuing State/Province ______

Driver's Address
Street Address: ______ City: ______ State/Province: ______ Zip Code: ______

CLP/CDL Applicant/Holder ○ Yes ○ No

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