VANDERBILT UNIVERSITY

MEDICAL CENTER

DRIVING HISTORY QUESTIONNAIRE

Your Name: _____ Date: _____

1. Do you have a valid license or permit? Yes □ No □
   If yes, license/permit #: _____ Expiration date: _____
2. Are you currently driving? Yes □ No □ If not, when did you stop driving: _____
3. Vehicle Information: Make _____ Model _____ Year _____
   Automatic transmission □ Standard transmission □
4. Are you or do you plan to drive at night? Yes □ No □
5. Are you or do you plan to drive on the interstate? Yes □ No □
6. In what areas do you typically drive? City □□□ Community □
   Please specify: _____
7. Have you had any accidents within the past 5 years, even if not your fault? Yes □ No □
8. Have you had any tickets within the past 5 years? Yes □ No □
9. Has your license ever been revoked, suspended, or lost? Yes □ No □
10. Are you currently taking medicine? Yes □ No □
    If yes, please list, or list any changes if you have recently seen another Vanderbilt provider:
    _____
11. Have you had a seizure or fainted within the past 6 months? Yes □ No □
    If yes, give date of last seizure or fainting: _____
12. Do you wear glasses for reading? Yes □ No □
13. Do you wear glasses for driving? Yes □ No □
14. Do you have blurred or double vision? Yes □ No □
15. Do you have difficulty seeing to the right? Yes □ No □
16. Do you have difficulty seeing to the left? Yes □ No □
17. Do you have diabetes? Yes □ No □ If so, what was your last A1C? _____
18. Do you have a history of cataracts? Yes □ No □
19. Do you have a history of glaucoma? Yes □ No □
20. Do you have macular degeneration? Yes □ No □
21. Do you require assistance for self-care/daily activities? Yes □ No □
22. Can you transfer independently in / out of car? Yes □ No □
23. Is your hearing normal? Yes □ No □
24. Do you wear a hearing aid? Yes □ No □