VMS DRUG TESTING

2423 US Highway 2 E
Kalispell, Montana 59901

DOT Physical Registration

First Name _____MI_____Last_____ DOB _____

Address _____City_____State_____Zip_____

Driver's License # _____ Issuing State_____

____ Self Pay ____ My Employer Pays Employer _____

1. Have you had a heart attack or had stents placed? ___Yes ___No
2. Do you have any other heart problems? ___Yes ___No
3. Do you use a CPAP machine? ___Yes ___No
4. Do you use Insulin for Diabetes? ___Yes ___No
5. Do you take Coumadin (Warfarin) or other blood thinners? ___Yes ___No
6. List all medications and supplements you currently take _____

_____

HIPAA Privacy and Consent: My signature below represents my consent to medical exams, treatment, and drug/alcohol testing provided by VMS Drug Testing & David Smith CFNP, their employees, and agents. My signature is also authorization for VMS Drug Testing, its affiliates, employees, and agents to disclose protected health information to my employer and/or the Department of Transportation when applicable. I understand I have the right to revoke this authorization by providing written notice to VMS Drug Testing. However, this authorization may not be revoked if VMS Drug Testing employees or agent have taken action on this authorization prior to receiving written notice. I understand I have the right to a copy of this authorization.

Signature_____Today's Date_____

For Office Use Only:

Blood Pressure: Systolic_____ Diastolic_____ **Heart Rate:**_____beats per min

Urinalysis: Visual: ___Clear ___Cloudy PH_____ Specific Gravity_____

Protein_____ Glucose_____ WBC_____ Blood detected?_____

Drug test performed same day? ___Yes ___No

Height: _____inches **Weight:**_____lbs

Vision:_____ **Hearing (whisper test):** ___Pass ___Fail

Identification verified? ___Yes ___No

Medical Assistant _____ _____ date_____