



HAGERTY MARINE MEDICAL STATEMENT

Insured's Name			Home Phone:		
Mailing Address			Work Phone:		
City	State	Zip	Cell Phone:		

DRIVER INFORMATION

Driver's Name	Date of Birth	Age	Sex	Occupation
Employer's Name and Address	Family Physician's Name and Address		Years Under Care	Date of Last Visit

DRIVER MEDICAL HISTORY

Explain all "Yes" responses in remarks section – include question number and explanation.

EYESIGHT

1. HAVE YOU LOST USE/SIGHT OF EITHER EYE? Y N
2. IS PERIPHERAL (SIDE) VISION RESTRICTED? Y N
3. ARE YOU COLOR BLIND? Y N
4. DO YOU HAVE OR HAVE YOU EVER HAD CATARACTS? Y N
5. ARE SIGHT DEFICIENCIES CORRECTED BY GLASSES/CONTACTS? Y N
6. DATE OF LAST EXAMINATION: _____

HEARING

7. ARE YOU UNABLE TO HEAR NORMAL CONVERSATION LEVEL? Y N
8. IS A HEARING AID USED? Y N

HEART

9. HAVE YOU EVER BEEN TREATED FOR HEART DISEASE? Y N
10. HAVE YOU EVER HAD A HEART ATTACK? Y N
11. DO YOU HAVE A PACEMAKER? Y N
12. MEDICATIONS/DOSAGE USED: _____
13. DATE OF LAST TREATMENT OR CHECK-UP: _____

LIMBS

14. HAVE YOU LOST AN ARM OR A LEG? Y N
15. HAVE YOU LOST THE USE OF AN ARM OR A LEG? Y N
16. DOES BOAT HAVE SPECIAL CONTROLS? Y N

DIABETES

17. HAVE YOU EVER BEEN TESTED FOR DIABETES? Y N
- LATEST BLOOD SUGAR TEST: _____
- MEDICATION/DOSAGE USED: _____
- METHOD OF ADMINISTRATION: _____

EPILEPSY

18. HAVE YOU EVER BEEN TREATED FOR EPILEPSY? Y N
- IF YES, DATE OF LAST TREATMENT: _____
- MEDICATION/DOSAGE USED: _____

BLOOD PRESSURE

19. HAVE YOU EVER BEEN TREATED FOR HIGH BLOOD PRESSURE? Y N
- IF YES, DATE OF LAST TREATMENT: _____
- LAST READING: _____
- MEDICATION/DOSAGE USED: _____

MISCELLANEOUS

20. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROLOGICAL, MENTAL OR EMOTIONAL PROBLEM? Y N
21. HAVE YOU EVER BEEN TREATED OR RECEIVED MEDICATION FOR ANY NEUROMUSCULAR DISEASE (MUSCULAR DYSTROPHY, MULTIPLE SCLEROSIS, CEREBRAL PALSY, ETC.)? Y N
22. ARE THERE ANY RESTRICTIONS POSTED ON YOUR DRIVERS LICENSE (OTHER THAN GLASSES/CONTACTS)? Y N
23. INDICATE DATE OF LAST TREATMENT, IF APPLICABLE:
- CONVULSIONS: _____
- FAINING SPELLS: _____
- LOSS OF EQUILIBRIUM: _____
- MENTAL/EMOTIONAL ILLNESS: _____
- ALCOHOL/DRUG ABUSE: _____
- COMPLETE PHYSICAL EXAMINATION: _____
24. ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE? Y N
- IF YES, PLEASE EXPLAIN: _____

REMARKS

I declare to the best of my knowledge and belief that all the above statements are true.	Driver's Signature _____	Date _____
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