

Potential Bioptic Driver Previous Driving History

Driver's License Status:

Have you never been licensed to drive an automobile? Yes No
If yes, have you driven even though you are not licensed? Yes No

Have you previously been or are you currently licensed to drive? Yes No
If Yes, please answer the following questions:

Number of Years Driving: _____ State Licensed In: _____

Is Your License Active? Yes No If Yes, Expiration Date _____

Are you still driving on your active license? Yes No

Do/did you have a restricted or waived driver's license? Yes No

Have you been a licensed bioptic driver? Yes No

If Yes, what state? _____ Year licensed _____

Do you have a CDL license? Yes (Federal or State) No

If Yes, is your license: Active Expired Suspended

Is your general license suspended? Yes No

If yes, why? _____

If Your License is Expired, Approx Date License Expired _____

Do You Drive on Your Expired License? Yes No

If No, when did you discontinue driving? _____

Why did you stop driving? _____

Did a doctor advise you to stop driving? Yes No

For Current Drivers Only:

What is your current driving pattern?

_____ Drives day and night routinely

_____ Drives day and night, but very limited

_____ Drives daytime only

Do you adjust your driving by time of day or sunlight position such as avoiding low-lying sun? Yes No

Please Explain:

For Current/Previous Drivers:

Accidents and Tickets History

Have you had any accidents in past five years? Yes No

If Yes, please explain.

Have you had any tickets or moving violations in past five years? Yes No
If Yes, please explain.

Have you been required to attend driving school due to violations/tickets?
Yes No When? _____

Has your license ever been suspended in the past? Yes No
For how long? _____ Has it been reinstated? Yes No

Have you ever had a Driving Under the Influence (DUIs)? Yes No

For All Potential Bioptic Drivers:

Driving Environment

Can you see the dashboard to read your speed? Yes No
You have problems seeing traffic signals or signs? Yes No
Have problems seeing traffic lights in bright lighting? Yes No
Are traffic lights more difficult to see? Yes No
Are some colors of signs/lights more difficult to see? Yes No
Do you have difficulty with the glare from headlights? Yes No
Do you wear sunglasses? Yes No

General Questions

Does your family support your driving ability? Yes No
Do you use GPS? Yes No

Your normal driving radius from your home is:
5 miles 10 miles 25 miles 50 miles or more

Your home/driving area is:
Rural/small town Urban/larger city Mixed

Other Medical Factors

Do you have any hearing problems? Yes No
Do you have difficulty with your night vision? Yes No
Do you full use of your hands, arms and legs? Yes No
Do you difficulty in turning your neck Yes No

Review of Medications

Review of all medications for drugs that may induce drowsiness and/or
cause poor dark adaptation.