



INTERNATIONAL HOT ROD ASSOCIATION  
 300 CLEVELAND ROAD  
 NORWALK, OHIO 44857  
 PHONE: 419-663-6666 FAX: 419-668-6601

### MEDICAL PHYSICAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (For each "yes" checked describe conditions in remarks)

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	a. frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	g. heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	m. nervous trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	s. medical rejection from service
<input type="checkbox"/>	<input type="checkbox"/>	b. dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	h. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	n. any drug or narcotic habit	<input type="checkbox"/>	<input type="checkbox"/>	t. admission to hospital
<input type="checkbox"/>	<input type="checkbox"/>	c. unconsciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>	i. stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	o. excessive drinking habit	<input type="checkbox"/>	<input type="checkbox"/>	u. rejection for life insurance
<input type="checkbox"/>	<input type="checkbox"/>	d. eye trouble except glasses	<input type="checkbox"/>	<input type="checkbox"/>	j. kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	p. attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	v. record of traffic convictions
<input type="checkbox"/>	<input type="checkbox"/>	e. hay fever	<input type="checkbox"/>	<input type="checkbox"/>	k. sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	q. motion sickness requiring drugs	<input type="checkbox"/>	<input type="checkbox"/>	w. record of other convictions
<input type="checkbox"/>	<input type="checkbox"/>	f. asthma	<input type="checkbox"/>	<input type="checkbox"/>	l. epilepsy or fits	<input type="checkbox"/>	<input type="checkbox"/>	r. military medical discharge	<input type="checkbox"/>	<input type="checkbox"/>	x. other illnesses

**REMARKS:** (if no changes since last report, so state) \_\_\_\_\_

### MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

Date	Name of Physician Consulted	Reason

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

**APPLICANTS' DECLARATION:** *I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for insurance of any IHRA certificate to me.*

**REPORT OF MEDICAL EXAMINATION**

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE BOX
		1. Head, face, neck and scalp
		2. Nose
		3. Sinuses
		4. Mouth and throat
		5. Ears, general (internal and external canals)
		6. Ear Drums (perforation)
		7. Eyes, general (visual activity under items 50 &51)
		8. Ophthalmoscopic
		9. Pupils (equality and reaction)
		10. Ocular mobility (associated parallel movement, mystaginus)
		11. Lungs and chest (including breasts)
		12. Heart ( thrust, size, rhythm, sounds)
		13. Vascular system
		14. Abdomen and viscera (including hernia)
		15. Endocrine system
		16. G-U system
		17. Upper and lower extremities ( strength, range of motion)
		18. Spine other musculoskeletal
		19. Skin and lymphatic
		20. Neuralgic (tendon reflexes, equilibrium, senses, coordination)
		21. Psychiatric (specify any personality deviation)
		22. General Systemic

**NOTES:** Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

Corrective lens required while driving		FIELD OF VISION	DISTANT VISION	NEAR VISION
<input type="checkbox"/> NO * if previously "yes", please include explanation of change	<input type="checkbox"/> YES	<input type="checkbox"/> Normal	Right eye	20/
		<input type="checkbox"/> Abnormal	Left eye	20/
			Both eyes	20/

**FIELD OF VISION** BLOOD SUGAR TEST  
(both fasting and 2 hour post prandial, required only if sugar is found in urine No S.I. Units))

RIGHT EYE	LEFT EYE	FASTING	2-HOUR P.P.	HgA 1C	COMMENTS

BLOOD PRESSURE			PULSE (Wrist)		
Recumbent MM Mercury	Systolic	Diastolic	Resting	After Exercise	2 minutes after exercise

URINALYSIS		OTHER TESTS
Albumen	Sugar	

**DISQUALIFYING DEFECTS/LIMITATIONS:**

**COMMENTS ON HISTORY AND FINDINGS:**

APPLICANTS NAME:	FURTHER EVALUATION REQUIRED (EXPLAIN):
PHYSICALLY ACCEPTABLE	

**MEDICAL EXAMINER'S DECLARATION:** I hereby certify that I personally examined the applicant named on this medical examination report, and that this report and any attachment embodies my findings completely and correctly.

EXAMINATION DATE	MEDICAL EXAMINER'S NAME AND ADDRESS	MEDICAL EXAMINER'S SIGNATURE