

North East Driver Medicals Questionnaire

The information you give will be treated as strictly confidential and will be stored in accordance with the Data Protection Act 1998

| | | | |
|------------|--|-----------|--|
| Surname | | DOB | |
| Forename | | | |
| Address | | | |
| | | Post code | |
| Mobile No. | | | |

Do you or have you ever suffered from anything below? Tick yes or no and give any relevant details?

| | | Yes | No | Details |
|---------------------------------|--|-----|----|---------|
| Section 1-Eyes | Do you suffer from any eye conditions that affect your vision e.g. double vision, glare, loss of parts of your vision? | | | |
| Section 2-Neurology | Have you ever had a TIA or stroke? | | | |
| | Have you ever had an unexplained episode of impaired consciousness/blackout/dizziness? | | | |
| | Have you ever had any serious brain injury, brain tumour, brain surgery, epileptic fit, narcolepsy or serious neurological disorder? | | | |
| Section 3-Heart and Circulation | History of heart attacks, angina or cardiac arrests? | | | |
| | Cardiac stents or bypass surgery? | | | |
| | Cardiac rhythm abnormality? | | | |
| | Heart valve disease or heart failure? | | | |
| | A pacemaker or ICD implant? | | | |
| | High blood pressure? | | | |
| | Vascular disease of the legs? | | | |
| | Aortic aneurysm? | | | |
| | Any other serious heart condition? | | | |

| | | Yes | No | Details |
|---------------------------|--|-----|----|---------|
| Section 4- Diabetes | Are you Diabetic? (If not, go to section 5) | | | |
| | Are you treated with diet only? | | | |
| | Are you treated with tablets? (If so, please list on page 3) | | | |
| | Are you treated with insulin or any other injectable treatment? | | | |
| | Do you check your blood sugars twice a day? | | | |
| | Do you check your sugar two hours before driving and every two hours whilst driving ? | | | |
| | If on insulin, do you have a three month memory stick record of your blood sugars? | | | |
| | Have you ever have a "hypo" (low blood sugar/hypoglycaemic attack)? | | | |
| | If you have hypos, do you have full awareness of them? | | | |
| | Do you keep a fast acting carbohydrate within easy reach whilst driving? | | | |
| | Do you have a full understanding of diabetes and its complications? | | | |
| | Do you have any diabetic complications (eg eye, kidney or peripheral neuropathy)? | | | |
| Section 5- Respiratory | Do you have sleep apnoea syndrome? | | | |
| | If you do have sleep apnoea syndrome are you compliant with treatment, are your symptoms controlled and do you have an annual check? | | | |
| | Do you have any lung disorder that makes you very breathless? | | | |
| Section 6- Psychiatric | Have you ever had any major psychiatric illness (severe depression, suicidal tendency, psychosis or bipolar disorder)? | | | |
| | Do you have a history of significant alcohol or drug issues? | | | |
| | How many units of alcohol do you drink per week? | | | |

| | | Yes | No | Details |
|-----------------------|--|-----|----|---------|
| Section 7– General | Do you have any physical disabilities (eg arm or leg deformity) that might affect your ability to drive? | | | |
| | Do you have severe deafness? | | | |
| | Do you take any medication that might cause drowsiness (eg strong pain killers or sedatives)? | | | |
| | Do you suffer from excessive day time sleepiness? | | | |
| | Do you have liver or kidney disease? | | | |
| | Have you had any cancer diagnosis in the past? | | | |

Please list below any drugs you are regularly prescribed by your doctor-

| Name of drug |
|--------------|
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
| 6 |

The declaration

I have attended for a vocational medical examination. I have answered questions regarding my medical history, and, to the best of my knowledge and belief, they are correct. I give permission for a copy of these notes to be sent to my usual GP and for them to contact the examining doctor in the event of anything serious in the judgment of the attached medical should I have omitted any important details.

I understand that I must inform the DVLA or other Licencing Authority of any significant change in my health.

| | |
|---------------|--|
| Name | |
| Signed | |
| Date | |

NEDM administration (Doctor's use only)

| | | | | |
|------------------|-----------------|--|----------|--|
| Photo ID checked | Driving Licence | | Passport | |
|------------------|-----------------|--|----------|--|