Drivers medical questionnaire – Medical in Confidence

Name	Date of birth	Date of assessment

Do you have, or have you ever had any of the following?

		YES	NO
1	Impairment of vision.	☐	☐
2	Difficulty seeing well enough to drive when there is glare or poor visibility such as fog.	☐	☐
3	Fits, epilepsy, fainting or blackouts.	☐	☐
4	Attacks of dizziness or vertigo.	☐	☐
5	Weakness, loss of sensation or clumsiness affecting part of your body.	☐	☐
6	Severe head injury or brain surgery.	☐	☐
7	Difficulty hearing normal conversation.	☐	☐
8	Trouble with your back or neck causing absence from work or a change in duties.	☐	☐
9	Any form of cancer.	☐	☐
10	Diabetes.	☐	☐
11	Psychiatric illness including depression or anxiety.	☐	☐
12	Dependency on or misuse of alcohol, drugs or other substances.	☐	☐
13	Disease of the heart or circulation including angina, heart attack or heart valve problems.	☐	☐
14	Abnormal heart rhythm or irregular heartbeat.	☐	☐
15	High blood pressure.	☐	☐
16	Any serious medical condition that may result in you being a danger to yourself or others when driving.	☐	☐

List any medication that you are taking

If you answered yes to any question please write any comments in this space

