**Health Fitness to Drive Questionnaire**

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| **Surname:** | **Forename:** |
| **Date of Birth:** | **Date:** |
| **Faculty / Directorate:** | **Line Manager:** |

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| **Have you ever suffered from any of the following:***If* ***Yes*** *please give full details and dates in the box at the end of this form* |  |
| Diabetes (diet, tablet or insulin controlled)? | **YES / NO** |
| Epilepsy or any unexplained loss of consciousness with liability to recurrence? | **YES / NO** |
| Heart Problems and/or had an ECG (heart trace) / Myocardial Infarction / Heart Surgery or Procedure / Heart Valve Disorders? | **YES / NO** |
| Angina | **YES / NO** |
| High Blood Pressure / CVA (stroke) / TIA (Transient Ischaemic Attack) / Aortic Aneurysm / Peripheral Arterial Disease? | **YES / NO** |
| Dizziness/Vertigo/Meniere’s Disease? | **YES / NO** |
| Visual Disturbances? | **YES / NO** |
| Hearing Problems? | **YES / NO** |
| Head Injury/Brain Surgery/Brain Tumour/Parkinson’s Disease/Muscular Sclerosis or other Chronic Neurological Disorder? | **YES / NO** |
| Psychological Disorder/Psychotic or Serious Psychiatric/Dementia? | **YES / NO** |
| Over 1 month off sick or shorter if the illness has affected your ability to drive? | **YES / NO** |
| Are you currently taking any medicines? | **YES / NO** |
| Are you taking any non-prescribed drugs? | **YES / NO** |
| Have you had any alcohol and/or drug misuse in the past 1 year or alcohol and/or drug dependency in the past 3 years? | **YES / NO** |
| How many units of alcohol do you consume in a week?(A unit is half pint of standard beer, 1 small glass wine, 1 shot glass sherry) | **YES / NO** |
| Any Sleep Disorder or Sleep Apnoea? | **YES / NO** |
| Is there any disability of the spine or limbs likely to impair control of the vehicle? | **YES / NO** |
| History of cancer? | **YES / NO** |
| Any history of kidney or liver failure? | **YES / NO** |
| Any history of sleep apnoea and/or medical condition causing excessive daytime sleepiness? | **YES / NO** |
| **Details of Specialist Appointments:** |  |
| Do you suffer from any other serious medical condition likely to affect the safe driving of a Passenger Carrying Vehicle / Public Service Vehicle? | **YES / NO** |
| Is there anything you are aware of that could adversely affect you driving long distance? | **YES / NO** |
| Do you have any difficulty in communicating by telephone in an emergency? | **YES / NO** |
| **If the answer to any of the above questions is YES, please include details here:** |  |
| **Employee Signature:** | **Date:** |
| **Medical standards for this health surveillance correspond to those issued by the DVLA, Drivers Medical Group under the title: “At a glance Guide to the current medical standards of fitness to drive”** |

**Occupational Health Section:**

**Measurements**

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| **BP:** **Height:****Weight:**  | **Urinalysis:** | **Visual acuity:** **Aided Rt: 6/ Lt: 6/** **Unaided Rt: 6/ Lt 6/**  |
| **Locomotor system:****Neck****Upper limbs****Back****Lower limbs** |  | **Visual fields: Type of test performed -****Right****Left** |
| **Any Other Comments:****NB:** Renewal Age 1 medical up to age 40; 40-50 5 yearly; 50-60 3 yearly; 60+ annualEach case is examined individually and the OHA can advise alternative assessment intervals. **Renewal date:** |
| **OH Advisor Signature:** | **Date:** |