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

**Part 1 General**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Title (Mr, Mrs etc.)** |  | | | | | |
| **Surname** |  | | | **DOB** | |  |
| **Forename(s)** |  | | | | | |
| **Address** |  | | | | | |
|  |  | | | | | |
| **Town** |  | | **Post Code** | |  | |
| **Home Tel No** |  | **Work Tel No** | | |  | |
| **Email** |  | | | | | |

**Are you currently receiving any care/treatment e.g. medication prescribed by your doctor? Please list below.**

**Please bring with you copy of prescription or copy of script request which is attached to your prescription.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name of Drug** | **Dose** | **Frequency** | **Reason** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |

**Consultant’s Details (if more than one please write on back of last page)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Name** |  |
| **Speciality** |  | **Speciality** |  |
| **Address** |  | **Address** |  |
| **Address** |  | **Address** |  |
| **Last Appointment Date** |  | **Last Appointment Date** |  |

**Part 2 Medical History (Please tick appropriate box Yes or No)**

**Do you have, or have you ever suffered from and if yes please give full details in section below or continue on reverse of back sheet.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **Details** |
| **Section 1 1** | Do you wear glasses/spectacles/contact lenses to drive? |  |  |  |
| **2** | Other eye conditions/problems with vision/eye disease/eye injury |  |  |  |
| **3** | Double vision? |  |  |  |
| **Section 2 4** | Fits/Epilepsy Seizure |  |  |  |
| **5** | Blackouts or fainting attacks |  |  |  |
| **6** | Dizziness or Vertigo (Meniere’s Disease) |  |  |  |
| **7** | Head injury (serious head injury) |  |  |  |
| **8** | Neurological Problems |  |  |  |
| **Section 3 9** | Liver Trouble e.g. jaundice |  |  |  |
| **Section 4 10** | Any Mental Health problems? |  |  |  |
| **11** | Problems with alcohol/drugs addiction? |  |  |  |
| **Section 5 12** | Any disease or problems of heart e.g. chest pains, angina |  |  |  |
| **13** | Heart attack (coronary thrombosis, cardiac infarction) |  |  |  |
| **14** | Irregular pulse (arrhythmia) palpitations |  |  |  |
| **15** | Pain in legs with walking e.g. claudication –circulation problems that affects your legs. |  |  |  |
| **16** | Heart murmurs/valve problems |  |  |  |
| **17** | Had stents? Stress ECG? Angiogram? Angina? Coronary artery by-pass graft surgery? ECG (when and what was the result) |  |  |  |
| **Section 6 18** | High blood pressure? Recent BP reading |  |  |  |
| **Section 7 19** | Cancer – ever suffered from? |  |  |  |
| **Section 8 20** | Defect of hearing |  |  |  |
| **21** | Do you wear a hearing aid? |  |  |  |
| **Section 9 22** | Diabetes |  |  |  |
| **23** | Kidney problems |  |  |  |
| **Section 10**  **24** | Back trouble e.g. lumbago, sciatica, slipped disc, backache |  |  |  |
| **25** | Joint problems e.g. rheumatism, arthritis |  |  |  |
| **26** | Have you been diagnosed with Sleep Apnoea? Date of doctor’s last review? |  |  |  |
| **27** | Snoring (How long has this been happening?) |  |  |  |
| **28** | Are you excessively tired throughout the day and lack energy? |  |  |  |
| **Section 11**  **29** | Any other medical condition that could affect your safe driving? |  |  |  |
| **30** | Have you had any other accidents or injuries that are relevant? |  |  |  |

**Part 3 Social History**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you Smoke? | Yes | No | Cigarettes/Cigars/Pipe | No. per Day | |  | | | | |
| Do you drink Alcohol? | Yes | No | How much do you drink per week? | Pints |  | | Glasses |  | Units |  |

|  |  |
| --- | --- |
| **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 Medical Practitioner and for him/her to contact the examining doctor, in the event of anything serious in the judgement of attached medical, should I have omitted any important details.** | |
| **I understand that I must inform the DVLA and other Licensing Authority of any significant changes in my health.** | |
| **Signed** |  |
| **Name** |  |
| **Date** |  |

**Medical Administration (Doctor’s Use Only)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Photo ID Checked** | | **Driving Licence** | | **Yes** | | **No** | **Passport** | | | | | **Yes** | | **No** |
| **Photo ID Checked** | | **Other….** | | | | | | | | | | **Yes** | | **No** | |
| **Blood Pressure** | | **1st Reading** |  | | **2nd Reading** | | |  | | **3rd Reading** | | |  | | |
| **Urine** |  | **Pulse** |  | | **Glasses Prescription** | | |  | | | | | | | |
| **Other relevant clinical findings** | |  | | | | | | | | | | | | | |
| **Doctor’s Name** | |  | | | | | | | **Date of Medical** | |  | | | | |
| **GMC Number** | |  | | | | | | | | | | | | | |