Driver Health Questionnaire - RETAINED BY REGISTERED MEDICAL PRACTITIONER

Patient Name: _____ DOB: _____

This questionnaire must be completed in order to help assess your fitness for driving a vehicle.

Please answer the questions by ticking the appropriate box or circling the appropriate response. If you are not sure, leave the question blank and ask the medical practitioner what it means. The medical practitioner may ask you more questions during the assessment.

1. Are you currently being treated by a doctor for any illness or injury? ❑No ❑ Yes

2. Are you receiving any medical treatment or taking any medication (prescribed or otherwise**)?** ❑No ❑ Yes

Please take any medications with you to show the doctor. Please note brief details: _____

3. Have you ever had, or been told by a doctor that you had any of the following? No Yes

	No	**Yes**		**No**	**Yes**
3.1 High blood pressure			3.13 Double vision, difficulty seeing		
3.2 Heart disease			3.14 Colour blindness		
3.3 Chest pain, angina			3.15 Kidney disease		
3.4 Any condition requiring heart surgery			3.16 Diabetes		
3.5 Palpitations/irregular heartbeat			3.17 Neck, back or limb disorders		
3.6 Abnormal shortness of breath			3.18 Hearing loss or deafness or had an ear operation or use a hearing aid		
3.7 Head injury, spinal injury			3.19 Do you have difficulty hearing people on the telephone (respond Yes if you require a hearing aid)?		
3.8 Seizures, fits, convulsions, epilepsy			3.20 Do you smoke or have you ever been a smoker?		
3.9 Blackouts or fainting			3.21 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?		
3.10 Migraine			3.22 Do you use illicit drugs?		
3.11 Stroke					
3.12 Dizziness, vertigo, problems with balance					

4. Please tick the box "**No**" or "**Yes**" in response to the following:

4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy? ❑No ❑ Yes

4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? ❑No ❑ Yes

Epworth sleepiness scale

4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

0 = would never doze off 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing Situation

Chance of dozing (0 to 3) 0 1 2 3

4.3.1 Sitting and reading	0	1	2	3
4.3.2 Watching TV				
4.3.3 Sitting, inactive in a public place (eg. In a theatre or meeting)				
4.3.4 As a passenger in a car for an hour without a break				
4.3.5 Lying down to rest in the afternoon when circumstances permit				
4.3.6 Sitting and talking to someone				
4.3.7 Sitting quietly after a lunch without alcohol				

4.3.8 In a car, while stopped for a few minutes in the traffic					

5. Do you drink alcohol? (If "No" please proceed to the Driver declaration below)

Please tick the answer that is correct for you

	(0)	**(1)**	**(2)**	**(3)**	**(4)**
5.1 How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.2 How many drinks containing alcohol do you have on a typical day when you are drinking? _____	1 or 2	3 or 4	5 to 6	7 to 9	10 or more
5.3 How often do you have six or more alcoholic drinks on one occasion? No	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.4 How often during the last year have you found that you were not able to stop drinking alcohol once you had started?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.5 How often during the last year have you failed to do what was normally expected from you because of drinking alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.6 How often during the last year have you needed a first alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.7 How often during the last year have you had a feeling of guilt or remorse after drinking alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more a week
5.9 Have you or someone else been injured as a result of your drinking alcohol?	No		Yes, but not in the last year		Yes, during the last year
5.10 Has a relative or friend, or a doctor or other health worker been concerned about your drinking alcohol or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Driver declaration

(In presence of medical practitioner) I, _____ (Print name) certify that to the best of my knowledge the above information supplied by me **is true and correct and that I am aware that it is an offence to provide false or misleading.**

Signature of applicant

_____

Signature of registered medical practitioner conducting examination

_____

Date _____ / _____ /_____

The completed questionnaire should be retained by the registered medical practitioner in the patient's medical file