



Questionnaire to assess your medical fitness to drive

1. Have you suffered a TIA? Yes No Date

a) Have you had multiple TIA's? Yes No

If Yes, please provide dates of the most recent TIA's.

DD MM YY

DD MM YY

DD MM YY

b) Do you have any residual problems? Yes No

2. Have you suffered a stroke? Yes No Date

a) Have you had multiple strokes? Yes No

b) Do you have any residual problems? Yes No

c) Are you able to walk at a brisk pace for 9 minutes? Yes No

If No, please give the reason why _____

3. Please give the date of your last and next appointment with your doctor and/or consultant (*for this condition*)

	Doctor			Consultant		
	DD	MM	YY	DD	MM	YY
Date of last appointment:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of next appointment:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Please give the name and dosage (the amount you take) of all current medication taken by you

Name of Medication	Dosage	Reason for taking

4a. Does your medication make you drowsy or confused when driving? Yes No

5. Have you needed rehabilitation? Yes No
(e.g. physiotherapy, speech therapy or occupational therapy)

If Yes, please give details of ongoing treatment _____

NAME:	DOB:	REF:
DRIVER NUMBER:		

6. Have you ever had a blackout(s)/altered level of consciousness? Yes No

If Yes, please give the date Date

7. Have you ever had any form of seizure? Yes No

If you have answered No to this question please go to Q10, If Yes, please indicate the diagnosis

Epileptic attacks are variably described and involve fits, convulsions or seizures. Epilepsy may also occur only as auras strange feelings or taste, absences or blank spells, limb jerking or twitching. Epileptic episodes may occur when asleep or when awake.

First ever seizure – If you tick this go to Q9

More than one seizure ever or epilepsy – If you tick this go to Q10

8. **First ever seizure** – Please provide the date of the seizure Date

Please give details _____

9. **More than one seizure ever or epilepsy** – Please provide the following dates:

	AWAKE		SLEEP
a) First awake seizure	<input type="text"/>	b) First sleep seizure	<input type="text"/>

c) Last 2 awake seizures	<input type="text"/>	d) Last 2 sleep seizures	<input type="text"/>
	<input type="text"/>		<input type="text"/>

e) If you have suffered both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack. Date

f) Are you currently on anti-epileptic medication? Yes No

g) If no longer treated, please give the date treatment stopped. Date

h) Have your seizures **ever** affected your level of consciousness? Yes No
If Yes, please go to Q10i, and if No, go to Q10j

i) Would your seizures have **ever** caused difficulty controlling a vehicle? Yes No

If No to Q10h or Q10i, please give a full description of the attack _____

j) Was your last seizure a result of advice from your doctor to either stop reduce or change your medication? Yes No
If No go to 10k. If yes, please answer the following questions

(i) Please give the date you started to reduce/change your medication Date

(ii) Has the previously effective epilepsy medication been restarted? Yes No

(iii) Please give the date the previously effective medication was restarted Date

(iv) Please give the date of your last seizure prior to the medication withdrawal or reduction of medication seizure Date

NAME:	DOB:	REF:
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DRIVER NUMBER:

k) If you have been advised by a doctor that your seizure was provoked, please provide full details of the circumstances of the seizure and the provoking factor _____

<p>Declaration</p> <p>This declaration needs to be signed if you have had a diagnosis of epilepsy or had more than one seizure.</p> <p>I agree to</p> <ul style="list-style-type: none">• follow the advice of my doctor(s) about my treatment for epilepsy.• attend where necessary, appointments to monitor my condition.• inform DVLA should I experience any further attacks <p>Signature _____ Date _____</p>
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10. Have you been advised by a healthcare professional that you have memory loss problems, episodes of confusion or difficulty with concentrating that affects safe driving? Yes No

11. Do you need help from another person with your day to day living? Yes No

If Yes, please give the details of how they help you _____

12. Has your condition caused problems with your eyesight? Yes No
(Such as your visual field, double vision)

If Yes, please give details of how your eyesight is affected: _____

13. Do you **need** to drive a Group 1 vehicle fitted with special controls or automatic transmission? Yes No

a) Do you **need** to drive a Group 2 vehicle fitted with special controls or automatic transmission? Yes No

b) Have you told us before that your need special controls or automatic transmission? Yes No

c) Since your last licence was issued have you had any addition controls fitted to your vehicle? Yes No

NAME:	DOB:	REF:
DRIVER NUMBER:		



Consent to the release of medical information

IMPORTANT: Please read the following information carefully and sign and date the statement below and return this consent form with your questionnaire. We cannot proceed with enquiries into your fitness to drive until we receive both your completed questionnaire and consent form

- We have asked you for your consent for the release of medical reports from your doctors as we may require further information.
- As part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment.
- Such personnel might include Doctors, Orthoptists, Paramedical Staff or officers of the Secretary of State. Only information relevant to the assessment of your fitness to drive will be released.
- Where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more of the Secretary of State’s Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

All data held by DVLA is used for internal evaluation of the quality of our services.

This section must NOT be altered in any way.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State’s medical adviser.

I authorise the Secretary of State to disclose such relevant personal and medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Orthoptists, Paramedical staff or Officers of the Secretary of State.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief they are correct.

“I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.”

Name: _____

Signature: _____ Date: _____

I authorise the Secretary of State to :

Inform my Doctor(s) of the outcome of my case Yes No

Release my medical information, and any other relevant information, to my doctor(s) by postal or electronic (fax or email) channels Yes No

If you would like to be contacted about your application by email or Text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS Text in relation to this application (Please Tick): Email Yes No SMS (Text) Yes No

If you tick either of these options, DVLA will contact you using an external service provider regarding this application only. Your email / mobile details will not passed on to any other Third Parties, or used for marketing purposes.

NAME:	DOB:	REF:
DRIVER NUMBER:		



Note: please fill in and return all pages (1-5) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (6) for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving

