



Medical Examination Report

To be completed by the Doctor and by the Patient at section 9 and 10 in the Doctor's presence (please use black ink)



- Before completing this form, please read Section B (page 6) of the INF4D – 'Information and useful notes' booklet, supplied with this report.
- Please answer **all** questions.

Please give patient's weight (kg/st) height (cms/ft)

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

Is the urine analysis positive for Glucose? No Yes (please tick appropriate box)

Details of specialist(s)/consultants, including address	1	2	3
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date last seen	<input type="text"/>	<input type="text"/>	<input type="text"/>
	medication	dosage	reason taken
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date when first licensed to drive a lorry and/or bus

1 Vision (Please see Eyesight notes on page 8 and 9 of leaflet INF4D)

Please tick ✓ the appropriate box(es)

	YES	NO
1. Is the visual acuity at least 6/9 in the better eye and at least 6/12 in the other? (corrective lenses may be worn) as measured with the full size 6m snellen chart	<input type="checkbox"/>	<input type="checkbox"/>
2. Do corrective lenses have to be worn to achieve this standard? If YES , is the:-	<input type="checkbox"/>	<input type="checkbox"/>
(a) uncorrected acuity at least 3/60 in the right eye?	<input type="checkbox"/>	<input type="checkbox"/>
(b) uncorrected acuity at least 3/60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	<input type="checkbox"/>	<input type="checkbox"/>
(c) correction well tolerated?	<input type="checkbox"/>	<input type="checkbox"/>
3. Please state the visual acuities of each eye in terms of the 6m Snellen chart. Please convert any 3 metre readings to the 6 metre equivalent.		
Uncorrected	Corrected (if applicable)	
Right <input type="text"/> Left <input type="text"/>	Right <input type="text"/>	Left <input type="text"/>
4. Is there a defect in his/her binocular field of vision (central and/or peripheral)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there diplopia? (controlled or uncontrolled)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the applicant have any other ophthalmic condition? If YES to 4, 5 or 6, please give details in Section 7 and enclose any relevant visual field charts or hospital letters.	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's name DOB



2 Nervous System

1. Has the applicant had any form of epileptic attack?	YES	NO						
	<input type="checkbox"/>	<input type="checkbox"/>						
(a) If Yes , please give date of last attack	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y			
(b) If treated, please give date when treatment ceased	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y			
(c) Is the applicant currently on anti-epileptic medication?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please complete current medication on the appropriate section on the front of this form								
2. Is there a history of blackout or impaired consciousness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please give date(s) and details in Section 7								
3. Does the applicant suffer from narcolepsy/cataplexy?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please give details in Section 7								
4. Is there a history of, or evidence of any of the conditions listed at a–h below?	YES	NO						
	<input type="checkbox"/>	<input type="checkbox"/>						
If NO , go to Section 3 .								
If YES , please tick the relevant box(es) and give dates and full details at Section 7 .								
(a) Stroke/TIA <i>please delete as appropriate</i>	<input type="checkbox"/>							
If YES , please give date	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	has there been a full recovery?
D	D	M	M	Y	Y			
(b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	<input type="checkbox"/>	<input type="checkbox"/>						
(c) Subarachnoid haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>						
(d) Serious head injury within the last 10 years	<input type="checkbox"/>	<input type="checkbox"/>						
(e) Brain tumour, either benign or malignant, primary or secondary	<input type="checkbox"/>	<input type="checkbox"/>						
(f) Other brain surgery	<input type="checkbox"/>	<input type="checkbox"/>						
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>						
(h) Dementia or cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>						

3 Diabetes Mellitus

	YES	NO						
1. Does the applicant have diabetes mellitus?	<input type="checkbox"/>	<input type="checkbox"/>						
If NO , please proceed to Section 4								
If YES , please answer the following questions.								
2. Is the diabetes managed by:-								
(a) Insulin?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please give date started on insulin	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	
D	D	M	M	Y	Y			
(b) Exenatide/Byeta	<input type="checkbox"/>	<input type="checkbox"/>						
(c) Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please complete current medication on the appropriate section on the front of this form								
(d) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>						
3. Does the applicant test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>						
4. Is there evidence of:-								
(a) Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>						
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>						
(c) Diminished/Absent awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>						
5. Has there been laser treatment for retinopathy?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES , please give date(s) of treatment	<input style="width: 200px;" type="text"/>							
6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	<input type="checkbox"/>	<input type="checkbox"/>						
If YES to any of 4–6 above, please give details in Section 7								

Applicant's name

DOB

4 Psychiatric Illness

YES NO

Is there a history of, or evidence of any of the conditions listed at 1–6 below?

If **NO**, please go to **Section 5**

If **YES** please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**.

NB. Please enclose relevant hospital notes

NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

YES

1. Significant psychiatric disorder within the past 6 months

2. A psychotic illness within the past 3 years, including psychotic depression

3. Persistent alcohol misuse in the past 12 months

4. Alcohol dependency in the past 3 years

5. Persistent drug misuse in the past 12 months

6. Drug dependency in the past 3 years

5 Cardiac

Please follow the instructions in all Sections (5A–5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 1.

5A Coronary Artery Disease

YES NO

Is there a history of, or evidence of, coronary artery disease?

If **NO**, proceed to **Section 5B**

If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Acute Coronary Syndrome including Myocardial Infarction?

If **Yes**, please give date(s)

2. Coronary artery by-pass graft surgery?

If **Yes**, please give date(s)

3. Coronary Angioplasty (P.C.I)

If **Yes**, please give date(s)

4. Has the applicant suffered from Angina?

If **Yes**, please give the date of the last attack

Please proceed to next **Section 5B**

Applicant's name

DOB

5B Cardiac Arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? YES NO

If **NO**, proceed to **Section 5C**

If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Has there been a **significant** disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?
3. Has a cardiac defibrillator device (I.C.D) been implanted?
4. Has a pacemaker been implanted?
If **YES**:-
 - (a) Please supply date
 - (b) Is the applicant free of symptoms that caused the device to be fitted?
 - (c) Does the applicant attend a pacemaker clinic regularly?

Please proceed to next Section 5C

5C Peripheral Arterial Disease (excluding Buerger's Disease)

1. Is there a history or evidence of ANY of the below: YES NO

If **YES** please tick ✓ ALL relevant boxes below, and give details at **Section 7** of the form.

PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)

2. Does the patient have claudication?
If **YES** how long in minutes can the patient walk at a brisk pace before being symptom limited?
Please give details

AORTIC ANEURYSM

IF YES:

- (a) Site of Aneurysm: Thoracic Abdominal
- (b) Has it been repaired successfully?
- (c) Is the transverse diameter **currently** 5.5cms?

DISSECTION OF THE AORTA

IF REPAIRED SUCCESSFULLY:

- (d) Please provide sight of reports to confirm if available

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

Is there a history of, or evidence, of valvular/congenital heart disease? YES NO

If **NO**, proceed to **Section 5E**

If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Is there a history of congenital heart disorder?
2. Is there a history of heart valve disease?
3. Is there any history of embolism? (**not** pulmonary embolism)
4. Does the applicant currently have significant symptoms?
5. Has there been any progression since the last licence application? (if relevant)

Please proceed to next section 5E

Applicant's name

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5E Cardiac Other

YES NO

Does the applicant have a history of ANY of the following conditions:

- (a) a history of, or evidence of heart failure?
- (b) established cardiomyopathy?
- (c) a heart or heart/lung transplant?

If YES to any part of the above, please give full details in Section 7 of the form. If NO, proceed to next section 5F.

5F Cardiac Investigations

YES NO

This section must be completed for all applicants.

1. Has a resting ECG been undertaken?

If **YES**, does it show:-

- (a) pathological Q waves?
- (b) left bundle branch block?
- (c) right bundle branch block?

2. Has an exercise ECG been undertaken (or planned)?

If **YES**, please give date and give details in **Section 7**

Please provide if available

3. Has an echocardiogram been undertaken (or planned)?

(a) If **YES**, please give date and give details in **Section 7**

(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?

Please provide if available

4. Has a coronary angiogram been undertaken (or planned)?

If **YES**, please give date and give details in **Section 7**

Please provide if available

5. Has a 24 hour ECG tape been undertaken (or planned)?

If **YES**, please give date and give details in **Section 7**

Please provide if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?

If **YES**, please give date and give details in **Section 7**

Please provide if available

Please proceed to Section 5G

5G Blood Pressure

This section must be completed for all applicants

YES NO

1. Is today's best reading systolic pressure 180mm Hg or greater?

2. Is today's best reading diastolic pressure 100mm Hg or greater?

3. Is the applicant on anti-hypertensive treatment?

If YES, to any of the above, please supply today's best reading and three previous readings with dates, if available

Applicant's name

DOB

6 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? YES NO

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? YES NO

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination

3. Is the applicant profoundly deaf? YES NO
 If **YES**, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/text phone? YES NO

4. Is there a history of either renal or hepatic failure? YES NO

5. Does the applicant have sleep apnoea syndrome? YES NO

If **YES**, please supply details

(a) Date of diagnosis

D	D	M	M	Y	Y
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(b) Is it controlled successfully? YES NO

(c) If **YES**, please state treatment (d) Please state period of control

(e) Please provide neck circumference

(f) Please provide girth measurement in cms

(g) Date last seen by consultant

6. Is there any other **Medical Condition**, causing excessive daytime sleepiness? YES NO

If **YES**, please supply details

(a) Diagnosis

(b) Date of diagnosis

D	D	M	M	Y	Y
---	---	---	---	---	---

(c) Is it controlled successfully? YES NO

(d) If **YES**, please state treatment (e) Please state period of control

(e) Date last seen by consultant

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? YES NO

8. Does any medication currently taken cause the applicant side effects that could affect safe driving? YES NO

If **YES**, please supply details of medication

9. Does the applicant have any other medical condition that could affect safe driving? YES NO

If **YES**, please supply details

Applicant's name

DOB

7

Please forward copies of relevant hospital notes only. PLEASE DO NOT send any notes not related to fitness to drive

Applicant's name

DOB

Medical Practitioner Details

To be completed by Doctor carrying out the examination

8

Doctor's details

Name
Address
E-mail address
Fax number

Surgery Stamp

Signature of Medical Practitioner

Date

Applicant's Details

To be completed in the presence of the
Medical Practitioner carrying out the examination



Please make sure that you have printed your name and date of birth
on each page before sending this form with your application

9 Your details

Your full name
Your address
E-mail address

Date of Birth

D	D	M	M	Y	Y
---	---	---	---	---	---

Home telephone number

Work/Daytime number

About your GP/Group Practice

GP/Group name
Address
Telephone
E-mail address
Fax number

10 Applicant's consent and declaration

Consent and Declaration

This section **MUST** be completed and must **NOT** be altered in any way.
Please read the following important information carefully then sign the statements below.

Important information about Consent

On occasion, 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 at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release report/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 medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and Panel members, and to inform my doctor(s) of the outcome of the case where appropriate.

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."

Signature

Date