



# Medical Examination Report

To be completed by the Doctor (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 sample taken, positive for Glucose? No  Yes  (please tick appropriate box)

Details of specialist(s)/ consultants, including address	1	2	3

Specialty

Date last seen

Current medication including exact dosage and reason for each treatment

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.		
<b>Uncorrected</b>	<b>Corrected (if applicable)</b>	
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?	<input type="checkbox"/>	<input type="checkbox"/>

If YES to 4, 5 or 6, please give details in Section 7 and enclose any relevant visual field charts or hospital letters.

Applicant's name

DOB



## 2 Nervous System

	YES	NO						
1. Has the applicant had any form of epileptic attack?	<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; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">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; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y			
2. Is there a history of blackout or impaired consciousness within the last 5 years? If YES, please give date(s) and details in Section 7	<input type="checkbox"/>	<input type="checkbox"/>						
3. Does the applicant suffer from narcolepsy/cataplexy? If YES, please give details in Section 7	<input type="checkbox"/>	<input type="checkbox"/>						
4. Is there a history of, or evidence of any of the conditions listed at a-h below? If NO, go to Section 3. If YES, please tick the relevant box(es) and give dates and full details at Section 7.	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>						
(a) Stroke/TIA <i>please delete as appropriate</i>	<input type="checkbox"/>							
(b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	<input type="checkbox"/>							
(c) Subarachnoid haemorrhage	<input type="checkbox"/>							
(d) Serious head injury within the last 10 years	<input type="checkbox"/>							
(e) Brain tumour, either benign or malignant, primary or secondary	<input type="checkbox"/>							
(f) Other brain surgery	<input type="checkbox"/>							
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	<input type="checkbox"/>							
(h) Dementia or cognitive impairment	<input type="checkbox"/>							

## 3 Diabetes Mellitus

	YES	NO						
1. Does the applicant have diabetes mellitus? If NO, please proceed to Section 4 If YES, please answer the following questions.	<input type="checkbox"/>	<input type="checkbox"/>						
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; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y			
(b) Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>						
(c) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>						
3. Does the patient 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? If YES, please give date(s) of treatment	<input type="checkbox"/>	<input type="checkbox"/>						
	<input style="width: 300px; height: 20px;" type="text"/>							
6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party? If YES to any of 4-6 above, please give details in Section 7	<input type="checkbox"/>	<input type="checkbox"/>						

Applicant's name

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## 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.** 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 at Section 7.

**NB.** If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 5.

### 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. Myocardial Infarction?

If Yes, please give date(s)

2. Coronary artery by-pass graft?

If Yes, please give date(s)

3. Coronary Angioplasty (with or without stent)?

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

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## 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 the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?

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2. Has the arrhythmia been controlled satisfactorily for at least 3 months?

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3. Has a cardiac defibrillator device been implanted?

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4. Has a pacemaker been implanted?    
If YES:-
  - a) Has the pacemaker been implanted for at least 6 weeks?
  - b) Since implantation, is the patient now symptom free from this condition?
  - c) Does the applicant attend a pacemaker clinic regularly?

Please proceed to next Section 5C

## 5C Peripheral Arterial Disease

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

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

### PERIPHERAL ARTERIAL DISEASE

#### AORTIC ANEURYSM, IF YES:

- a. Site of Aneurysm: Thoracic  Abdominal  YES  NO
- b. Has it been repaired successfully:
- c. Is the transverse diameter more than 5cms:

#### DISSECTION OF THE AORTA, IF YES:

- a. Has it been repaired successfully:

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?

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2. Is there a history of heart valve disease?

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3. Is there any history of embolism? (not pulmonary embolism)

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4. Does the applicant currently have significant symptoms?

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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 Cardiomyopathy

	YES	NO
Does the applicant have a history of ANY of the following conditions:	<input type="checkbox"/>	<input type="checkbox"/>
(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
<b>This section must be completed for all applicants.</b>		
1. Has a resting ECG been undertaken?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, does it show:-		
(a) pathological Q waves?	<input type="checkbox"/>	<input type="checkbox"/>
(b) left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has an exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please give date and give details in Section 7 <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/>		
<i>Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful</i>		
3. Has an echocardiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please give date <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> and give details in Section 7		
<i>Sight/copy of the echocardiogram result/report would be useful</i>		
4. Has a coronary angiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please give date <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> and give details in Section 7		
<i>Sight/copy of the angiogram result/report would be useful</i>		
5. Has a 24 hour ECG tape been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please give date <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> and give details in Section 7		
<i>Sight/copy of the 24 hour tape result/report would be useful</i>		
6. Has a myocardial perfusion imaging scan been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please give date <input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YY"/> and give details in Section 7		
<i>Sight/copy of the scan result/report would be useful</i>		
Please proceed to Section 5G		

## 5G Blood Pressure

	YES	NO
<b>This section must be completed for all applicants</b>		
1. Is today's resting systolic pressure 180mm Hg or greater?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is today's resting diastolic pressure 100mm Hg or greater?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the applicant on anti-hypertensive treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, to any of the above, please supply today's reading <input type="text"/>		

Applicant's name

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**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?

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, has it been controlled successfully?

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

6a. If YES, please give full details below.


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 which impair his/her safe driving? YES  NO

Applicant's name

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Please forward copies of all relevant hospital notes if available

Applicant's name

DOB

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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 reports to the Secretary of State's medical adviser about my condition.

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 release to my doctor(s) details of the outcome of my case and any relevant medical information.

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.

Signature

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

# Medical Practitioner Details

To be completed by Doctor carrying out the examination

## 10 Doctor's details

Name
Address
E-mail address

Surgery Stamp

Signature of Medical Practitioner

Date