SEQOHS
Safe Effective Quality
Occupational Health Service

Centre for Occupational Health

Tel: 0161 419 5491. E-mail: OHGeneral@stockport.nhs,uk

NHS
Stockport
NHS Foundation Trust

DRIVER MEDICAL QUESTIONNAIRE

Please complete fully and bring to your appointment

Name.....DOB.....Job.....

Employer.....Work Location.....Contact tel .no.....

Home Address.....

Do you have currently / have you ever had: (please circle Yes or No)

Do you wear glasses or contact lenses , if so when did you last have an eye test at an optician	Y/N DETAILS
Any impairment of vision/ visual function uncorrected by glasses or contact lenses (impairment includes; reduced vision in one or both eyes , double vision, reduced horizontal or vertical visual fields, night blindness)	Y/N DETAILS
Any eye conditions that could result in impairment in vision (treated or untreated), for example - cataracts, glaucoma, retinopathy, retinitis pigmentosa, hemianopia, eyelid spasm	Y/N DETAILS
Any glare sensitivity, contrast sensitivity or impairment of twilight vision	Y/N DETAILS
Chronic neurological conditions/ fits/epilepsy fainting or blackouts	Y/N DETAILS:
Weakness, loss of sensation or clumsiness affecting any part of your body	Y/N DETAILS:
Narcolepsy	Y/N DETAILS:
Dementia	Y/N DETAILS:
Attacks of disabling dizziness/ vertigo /blackouts	Y/N DETAILS:
Sleep apnoea	Y/N DETAILS:
Severe head injury/ brain surgery/ brain tumour or subarachnoid bleed (in the last 10 years)	Y/N DETAILS:
Difficulty hearing normal conversation/ deafness	Y/N DETAILS:
Back or neck problems or restricted movements	Y/N DETAILS:
Any form of cancer/ tumour	Y/N DETAILS:
Diabetes Treatment / any complications of diabetes	Y/N DETAILS:
Kidney/ liver problems	Y/N DETAILS:
Psychiatric illness including depression or anxiety	Y/N DETAILS:
Dependency or misuse of alcohol, drugs or other substances	Y/N DETAILS:
Disease of the heart or circulation including angina, heart attack of heart valve problems Abnormal or irregular heartbeat Stroke/ TIA High blood pressure	Y/N DETAILS:
Severe respiratory (chest) disease	Y/N DETAILS:
Have you had any absence from work in the last two years related to the above	Y/N DETAILS:
Are you taking any medication If yes; - please state medication and dose - does your medication affect your driving	Y/N DETAILS:
Any medical condition that may result in you being a danger to yourself/ others when driving	Y/N DETAILS:
Do you considered yourself disabled	Y/N DETAILS:

Signature.....Date.....

Name:.....NI Number.....
Please print