

# Medical Examination Report



Driver and Vehicle Licensing Agency

To be filled in by the Doctor. The patient must fill in sections 9 and 10 in the doctor's presence (please use black ink).



- Before filling in this form, please read Section B (page 5) of the 'Information and useful notes' booklet (INF4D).
- Please ensure you fully examine the patient as well as taking the patient's history.
- Please answer **all** questions.

Patient's weight (kg)  Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

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

Details of type of specialist(s)/consultants, including address


Date of last appointment

DD	MM	YY	DD	MM	YY	DD	MM	YY
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medication	dosage	reason taken

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

## 1 Vision (Please see Eyesight notes on page 7 and 8 of leaflet INF4D)

**Please tick ✓ the appropriate box(es)**

	YES	NO
1. Is the visual acuity <b>at least</b> 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 <b>YES</b> , 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 <b>of each eye</b> 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 the patient's 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 patient 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.

Patient's name  Date of Birth



## 2 Nervous System

	YES	NO
1. Has the patient had any form of epileptic attack? If <b>YES</b> , please answer questions a–f	<input type="checkbox"/>	<input type="checkbox"/>
(a) Has the patient had more than one attack?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Please give date of first and last attack First attack <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> Last attack <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>		
(c) Is the patient currently on anti-epilepsy medication? If <b>YES</b> , please fill in current medication on the appropriate section on the front of this form	<input type="checkbox"/>	<input type="checkbox"/>
(d) If no longer treated, please give date when treatment ended <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>		
(e) Has the patient had a brain scan? If <b>YES</b> , please state: MRI <input type="checkbox"/> Date <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> CT <input type="checkbox"/> Date <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> Please supply reports if available	<input type="checkbox"/>	<input type="checkbox"/>
(f) Has the patient had an EEG? <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> If <b>YES</b> to any of above, please supply reports if available.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of blackout or impaired consciousness within the last 5 years? If <b>YES</b> , please give date(s) and details in <b>Section 7</b>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there a history of, or evidence of, any of the conditions listed at a–g below? If <b>NO</b> , go to <b>Section 3</b> . If <b>YES</b> , please tick the relevant box(es) and give dates and full details at <b>Section 7</b> and supply any relevant reports.	<input type="checkbox"/>	<input type="checkbox"/>
(a) Stroke or TIA <i>please delete as appropriate</i> If <b>YES</b> , please give date <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> Has there been a <b>full</b> recovery? Please provide copies of any carotid artery and/or other major cerebral artery imaging reports.	<input type="checkbox"/>	<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 or abnormality	<input type="checkbox"/>	
(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	<input type="checkbox"/>	

## 3 Diabetes Mellitus

	YES	NO
1. Does the patient have diabetes mellitus? If <b>NO</b> , please go to <b>Section 4</b> If <b>YES</b> , please answer the following questions.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the diabetes managed by:-		
(a) Insulin? If <b>YES</b> , please give date started on insulin <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
(d) A sulphonylurea or a Glinide?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Oral hypoglycaemic agents and diet? If <b>YES</b> , please fill in current medication on the appropriate section on the front of this form	<input type="checkbox"/>	<input type="checkbox"/>
(f) Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Does the patient test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Does the patient test at times relevant to driving?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the patient carry fast acting carbohydrate in the vehicle when driving?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?	<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"/>
5. Is there any evidence of impaired awareness of hypoglycaemia?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's name

Date of birth

6. Has there been laser treatment for retinopathy or intra-vitreous treatment for retinopathy?  **YES**  **NO**   
 If **YES**, please give date(s) of treatment
- 
7. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?  **YES**  **NO**   
 If **YES** to any of 4–6 above, please give details in **Section 7**

## 4 Psychiatric Illness

- Is there a history of, or evidence of, any of the conditions listed at 1–7 below? **YES**  **NO**   
 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 patient remains under specialist clinic(s), ensure details are filled in 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. Dementia or cognitive impairment
  4. Persistent alcohol misuse in the past 12 months
  5. Alcohol dependence in the past 3 years
  6. Persistent drug misuse in the past 12 months
  7. Drug dependence in the past 3 years

## 5 Cardiac

### 5A Coronary Artery Disease

- Is there a history of, or evidence of, Coronary Artery Disease? **YES**  **NO**   
 If **NO**, go to **Section 5B**
- If **YES**, please answer all questions below and give details at **Section 7** of the form and enclose relevant hospital notes.
1. Acute Coronary Syndromes including Myocardial Infarction?  **YES**  **NO**   
 If **YES**, please give date(s)
  2. Coronary artery by-pass graft surgery?  **YES**  **NO**   
 If **YES**, please give date(s)
  3. Coronary Angioplasty (P.C.I.)  **YES**  **NO**   
 If **YES**, please give date of most recent intervention
  4. Has the patient suffered from Angina?  **YES**  **NO**   
 If **YES**, please give the date of the last known attack

Please go to next Section 5B

Patient's name

Date of birth

## 5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO</b> , go to <b>Section 5C</b>		
If <b>YES</b> , please answer all questions below and give details in <b>Section 7</b> of the form.		
1. Has there been a <b>significant</b> 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	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a pacemaker been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> :-		
(a) Please supply date of implantation	<input type="text" value="D"/>	<input type="text" value="D"/>
	<input type="text" value="M"/>	<input type="text" value="M"/>
	<input type="text" value="Y"/>	<input type="text" value="Y"/>
(b) Is the patient free of symptoms that caused the device to be fitted?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the patient attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Please go to <b>Section 5C</b>		

## 5C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

	YES	NO
Is there a history or evidence of ANY of the following:	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please <b>tick</b> ✓ ALL relevant boxes below, and give details in <b>Section 7</b> of the form.		
If <b>NO</b> , go to <b>Section 5D</b>		
1. <b>PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have claudication?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , for how long in minutes can the patient walk at a brisk pace before being symptom-limited?		
Please give details <input style="width: 200px;" type="text"/>		
3. <b>AORTIC ANEURYSM</b>	<input type="checkbox"/>	<input type="checkbox"/>
IF YES:		
(a) Site of Aneurysm:	Thoracic <input type="checkbox"/>	Abdominal <input type="checkbox"/>
(b) Has it been repaired successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Is the transverse diameter <b>currently</b> > 5.5cms?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO</b> , please provide latest measurement and date obtained <input style="width: 50px;" type="text"/> <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
4. <b>DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY:</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide copies of all reports to include those dealing with any surgical treatment.		
Please go to <b>Section 5D</b>		

## 5D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence of, valvular/congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>NO</b> , go to <b>Section 5E</b>		
If <b>YES</b> , please answer all questions below and give details in <b>Section 7</b> of the form.		
1. Is there a history of congenital heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of heart valve disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there any history of embolism? ( <b>not</b> pulmonary embolism)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient currently have significant symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has there been any progression since the last licence application? (if relevant)	<input type="checkbox"/>	<input type="checkbox"/>
Please go to <b>section 5E</b>		

Patient's name

Date of birth

**5E Cardiac Other****YES NO**Does the patient 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?
- (d) Untreated atrial myxoma

**If YES, please give full details in Section 7 of the form. If NO, go to section 5F****5F Cardiac Investigations****This section must be filled in for all patients****YES NO**

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?

   
   
 *Please provide a copy of the ECG report (if available) or comment at Section 7*

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

 If **YES**, please give date       and give details in **Section 7***Please provide relevant reports 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 relevant reports if available*

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

 If **YES**, please give date       and give details in **Section 7***Please provide relevant reports 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 relevant reports 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 relevant reports if available***Please go to Section 5G****5G Blood Pressure****This section must be filled in for all patients****YES NO**

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

 

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

 Please give today's reading 

3. Is the patient on anti-hypertensive treatment?

 **If YES to any of the above, please provide three previous readings with dates, if available**  

Patient's name

Date of birth

**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**.

	YES	NO
1. Is there <b>currently</b> a disability of the spine or limbs likely to impair control of the vehicle?	<input type="checkbox"/>	<input type="checkbox"/>
2. (a) Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please give dates and diagnosis and state whether there is current evidence of dissemination		
(b) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the patient profoundly deaf?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> ,		
is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?		
	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a history of alcoholic liver disease and/or liver cirrhosis of any origin?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please give details in <b>Section 7</b>		
5. Is there a history of, or evidence of, sleep apnoea syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please provide details		
(a) Date of diagnosis	D D	M M Y Y
(b) Is it controlled successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(c) If <b>YES</b> , please state treatment	<input type="text"/>	(d) Please state period of control <input type="text"/>
(e) Please provide neck circumference	<input type="text"/>	
(f) Please provide girth measurement in cms	<input type="text"/>	
(g) Date last seen by consultant	<input type="text"/>	
6. Does the patient suffer from narcolepsy or cataplexy?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please give details in <b>Section 7</b>		
7. Is there any other <b>Medical Condition</b> causing excessive daytime sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please provide details		
(a) Diagnosis	<input type="text"/>	
(b) Date of diagnosis	D D	M M Y Y
(c) Is it controlled successfully?	<input type="checkbox"/>	<input type="checkbox"/>
(d) If <b>YES</b> , please state treatment	<input type="text"/>	(e) Please state period of control <input type="text"/>
(f) Date last seen by consultant	<input type="text"/>	
8. Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does any medication currently taken cause the patient side effects that could affect safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please provide details of medication and symptoms		
10. Does the patient have any other medical condition that could affect safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> , please provide details		

Patient's name

Date of birth

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

Patient's name

Date of Birth

## Medical Practitioner Details

To be filled in by Doctor carrying out the examination

Please ensure all relevant sections of the form have been filled in as, if not, this will cause the form to be returned for completion.

8

Doctor's details (please print name and address in capital letters)

Name
Address
Telephone
Email address
Fax number

Surgery Stamp or GMC Registration Number

Signature of Medical Practitioner

Date of Examination

# Patient's Details

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

D4

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
Email address

Date of Birth

D	D	M	M	Y	Y
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Home phone number

Work/Daytime number

### About your GP/Group Practice

GP/Group name
Address
Phone
Email address
Fax number

## 10 Patient's consent and declaration

### Consent and Declaration

This section **MUST** be filled in and must **NOT** be altered in any way.

Please read the following important information carefully then sign to confirm 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/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.

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:

	YES	NO
Inform my Doctor(s) of the outcome of my case	<input type="checkbox"/>	<input type="checkbox"/>
Release reports to my Doctor(s)	<input type="checkbox"/>	<input type="checkbox"/>