Gloucester City Council
Transforming Your City

Medical Examination Report

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 the attached 'Medical Examination Report - Information and useful notes' booklet Section B (page 5)

Patients 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

1	2	3

Date of last appointment D D M M Y Y D D M M Y Y D D M M Y Y

Medication	Dosage	Reason Taken

1 Vision

(please see Eyesight notes on page 7 of the attached 'Medical Examination Report - Information and useful notes' booklet

Please tick ✓ the appropriate box(es) **YES** **NO**

1. Is the visual acuity **at least** 6/7.5 in the better eye and at least 6/60 in the other? (corrective lenses may be worn) as measured with the full size 6m Snellen chart ☐ ☐

2. Do corrective lenses have to be worn to achieve this standard? ☐ ☐
   If **YES**, is the:-
   (a) uncorrected acuity at least 3/60 in the right eye? ☐ ☐
   (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)
   (c) correction well tolerated? ☐ ☐

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		Left		Right		Left	

4. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? ☐ ☐

5. Is there a defect in the patient's binocular field of vision (central and/or peripheral)? ☐ ☐

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6. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

7. Does the patient 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.

2 Nervous System

		YES	NO
1.	Has the patient had any form of epileptic attack?	☐	☐
	If **YES**, please answer questions a - f		
	(a) Has the patient had more than one attack?	☐	☐
	(b) Please give date of first and last attack		
	First attack D D M M Y Y Last attack D D M M Y Y		
	(c) Is the patient currently on anti-epilepsy medication?	☐	☐
	If **YES**, please fill in current medication on the appropriate section on the front of this form		
	(d) If treated, please give date when treatment ended D D M M Y Y		
	(e) Has the patient had a brain scan? If **YES**, please state:	☐	☐
	MRI ☐ Date D D M M Y Y CT ☐ Date D D M M Y Y		
	Please supply reports if available		
	(f) Has the patient had an EEG?	☐	☐
	If **YES**, please provide dates D D M M Y Y		
	Please supply reports if available		
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**		
3.	Is there a history of, or evidence of, any of the conditions listed at a-g below?	☐	☐
	If **NO**, go to **Section 3**		
	If **YES**, please tick the relevant box(es) and give dates and full details at **Section 7** and supply and relevant reports.		
	(a) Stroke/TIA *please delete as appropriate*	☐	
	If **YES**, please provide dates D D M M Y Y		
	Has there been a **full** recovery	☐	☐
	(b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	☐	
	(c) Subarachnoid haemorrhage	☐	
	(d) Serious head injury within the last 10 years	☐	
	(e) Brain tumour, either benign or malignant, primary or secondary	☐	
	(f) Other brain surgery/abnormality	☐	
	(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	☐	

3 Diabetes Mellitus

		YES	NO
1.	Does the patient have diabetes mellitus?	☐	☐
	If **NO**, please go to **Section 4**		
	If **YES**, please answer the following questions:		
2.	Is the diabetes managed by:		
	(a) Insulin?	☐	☐
	If **YES**, please give date started on insulin D D M M Y Y		
	(b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?	☐	☐
	(c) Other injectable treatments?	☐	☐
	(d) A sulphonylurea or a Glinide?	☐	☐
	(c) Oral hypoglycaemic agents and diet?	☐	☐
	If **YES**, please fill in current medication on the appropriate section on the front of this form		
	(d) Diet only?	☐	☐
3.	(a) Does the patient test blood glucose at least twice every day?	☐	☐
	(b) Does the patient test at times relevant to driving?	☐	☐
	(c) Does the patient carry fast acting carbohydrate in the vehicle when driving?	☐	☐
	(d) Does the patient have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐

4. Is there evidence of:
   (a) Loss of visual field? ☐ ☐
   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ ☐
5. Is there any evidence of impaired awareness of hypoglycaemia? ☐ ☐

6. Has there been laser treatment for retinopathy? ☐ ☐
   Or intra-vitreal treatment for retinopathy?
   If **YES**, please give date(s) of treatment

7. Is there a history of hypoglycaemia in the last 12 months requiring assistance of another person? ☐ ☐

If **YES** to any of 4 - 7 above, please give details in **Section 7**

4 Psychiatric Illness

	YES	NO
Is there a history of, or evidence of, any of the conditions listed in 1-7 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 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 dependency in the past 3 years	☐
6.	Persistent drug misuse in the past 12 months	☐
7.	Drug dependency in the past 3 years	☐

5 Cardiac

	YES	NO
Is there a history of, or evidence of, Coronary Artery Disease?	☐	☐

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

5A Coronary Artery Disease

		YES	NO
1.	Acute Coronary Syndromes including Myocardial Infarction? If **YES**, please give date(s) D D M M Y Y	☐	☐
2.	Coronary artery by-pass graft surgery? If **YES**, please give date(s) D D M M Y Y	☐	☐
3.	Coronary Angioplasty (P.C.I)? If **YES**, please give date of most recent intervention D D M M Y Y	☐	☐
4.	Has the patient suffered from Angina?	☐	☐

If **YES**, please give date of the last known attack | D | D | | M | M | | Y | Y |

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?	☐	☐

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

If **YES** please answer all questions below and give details in **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 the last 5 years	☐	☐
2.	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3.	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4.	Has a pacemaker been implanted?	☐	☐

If **YES**

(a) Please provide date D D M M Y Y

(b)	Is the patient free of symptoms that caused the device to be fitted?	☐	☐
(c)	Does the patient attend a pacemaker clinic regularly?	☐	☐

Please go to Section 5C

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

	YES	NO
Is there a history of, or evidence of, ANY of the following?	☐	☐

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

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

1.	**PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)**	☐	☐
2.	Does the patient have claudication?	☐	☐

If **YES** for how long in minutes can the patient walk at a brisk pace before being symptom limited?

Please give details ☐

3.	**AORTIC ANEURYSM**	☐	☐

IF YES:

(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

(b)	Has it been repaired successfully?	☐	☐
(c)	Is the transverse diameter **currently** >5.5cms?	☐	☐

If **NO**, please provide latest measurement and date obtained

☐ D D M M Y Y

4.	**DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY:**	☐	☐

If **YES** please provide copies of all reports to include those dealing with any surgical treatment.

Please go to Section 5D

5D Valvular/Congenital Heart Disease

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

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

If **YES** please answer all questions below and give details in **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 patient currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please go to Section 5E

Patient's Name: ☐ **Date of Birth:** ☐

5E Cardiac Other

	YES	NO
Does the patient have a history of **ANY** of the following	☐	☐
(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

	YES	NO
This section must be filled in for all patients		
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 D D M M Y Y 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 D D M M Y Y 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 D D M M Y Y 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 D D M M Y Y 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 D D M M Y Y and give details in **Section 7**		
Please provide relevant reports if available		

Please go to Section 5G

5G Blood Pressure

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

Patient's Name: **Date of Birth:**

7	**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

8 Doctor's Details

Name
Address
Email address
Fax number

Surgery Stamp or GMC Registration Number

Declaration:

PLEASE ENSURE THIS SECTION IS COMPLETED

1. I CERTIFY that having had regard to the DVLA's "Assessing Fitness to Drive – a guide for medical professionals" I have examined the applicant and confirm he/she in my opinion:

Meets the Group 2 entitlement of fitness to drive*

Does not meet the Group 2 entitlement of fitness to drive*

(*PLEASE DELETE AS NECESSARY).

	YES	NO
If the applicant is under 45 years of age do you consider a further examination necessary before the applicant reaches 45 years of age; or	☐	☐
If the applicant is over 45 do you consider a further medical examination necessary before 5 years time?	☐	☐

If YES to either statement in what period of time do you consider a further examination necessary

2. I have checked the applicant's photo identification and confirm that the applicants name is the same as that on his/her identification and his/her appearance is the same as that on his/her photograph. As such I assume he/she is the person on the photograph

Signature of Medical Practitioner:

Date of Examination:

Patient's Name: **Date of Birth:**

Patient's Details

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

9 Your Details

Your full name
Your address
Email address

Date of Birth D D M M Y Y

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

You must sign this declaration when you are with the doctor who is completing this report.

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Gloucester City Council in conjunction with my application and during the period that a licence (if granted) is in force.

I authorise Gloucester City Council to disclose such relevant information as may be necessary to the investigation of my fitness to drive in conjunction with my application and during the period that a licence (if granted) is in force to doctors, paramedical staff, and to inform my doctor(s) of the outcome of the case where appropriate.

I understand that Gloucester City Council may require me to undergo further medical tests at my expense now or at any point in the future, if a licence is granted, in order to establish my fitness to drive.

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

Signature of Applicant:

Date:

Patient's Name: **Date of Birth:**