BARNSLEY
Metropolitan Borough Council

Part 1 – Medical Questionnaire

To be completed by the applicant prior to the completion of Part 2 by examining doctor

Complete your details and answer the questions below before asking your examining doctor to complete Part 2 of this form. Please note that you will be responsible for any fees that are required to be paid for this service.

The completed form should be submitted online via the Barnsley Council website.

This form must be completed by all new applicants for driver licences and then by all drivers at the age of 45. Thereafter the questionnaire must be completed and certified every five years, until the licensee attains the age of 60 years whereupon the questionnaire and certification will be required annually. Holders of HGV and PSV licences will be exempt from completion of this form on production of the appropriate licence.

Driver's Full Name:		Date of Birth:	
Driver's Full Address:			
Postcode:		NI Number:	
Telephone Number:		Email Address:	
Name and Address of GP:			

Please answer all questions below, either by circling or deleting as appropriate.

1.	Are you at present suffering from, or have you in the past suffered from, any of the following particular illnesses?	
(a)	Epilepsy	YES / NO *
(b)	Sudden attacks of giddiness or fainting	YES / NO *
(c)	Any limb disability	YES / NO *
(d)	Heart disease (including angina) and disease of the coronary arteries	YES / NO *
(e)	Pulmonary tuberculosis	YES / NO *
(f)	Defective or deteriorating vision not corrected by spectacles or contact lenses	YES / NO *
(g)	Defective or deteriorating hearing	YES / NO *
2.	Are you taking any prescribed drugs at the present time? If so please specify the name of the drugs below	YES / NO *
3.	Have you had any prolonged absence from work during the last twelve months	YES / NO *
4.	Are you registered as disabled?	YES / NO *
5.	Have you any reason to suppose that you suffer from, or have suffered from, any form of ill health or mental or physical disability that might adversely affect the performance of your duties as a hackney carriage/ private hire driver?	YES / NO *
If you have answered **YES** to any of the questions above, please provide full details on page 2. Continue on a separate sheet if required		

Applicant's Full Name: …… Date of birth: D D / M M / Y Y

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The answers given by me are true to the best of my knowledge and belief and I give this information knowing that my licence will be refused or revoked if I have wilfully given any reply which I know to be false or do not believe to be true.

If my medical circumstances change I will notify the Licensing Section immediately in writing.

I consent, for a period of three years from the date of my signature, to the Authority's Medical Officer seeking information from any doctor who at any time has attended to me and I authorise the giving of such information.

Driver's Signature:		Date:	

If you have answered **YES** to any of the questions above please provide full details below, continue on a separate sheet if required

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Part 2a – Medical Examination Report

Visual Assessment

To be filled in by a doctor or optician/optometrist

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 can be ignored.

1. Please confirm by circling the scale you are using to express the driver's visual acuities	Snellen	Snellen expressed as a decimal	LogMAR	
2. Please state the visual acuity of each eye (see INF4D). Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.	Uncorrected		Corrected (using prescription worn for driving)	
	R	L	R	L
3. Is the visual activity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard?)	YES		NO	
4. Were corrective lenses worn to meet this standard? If **Yes**, please circle glasses, contact lenses or both together?	YES Glasses Contact Lenses Both		NO	
5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?	YES		NO	
6. If correction is worn for driving, is it well tolerated? If **No**, please give full details in the box provided.	YES		NO	
7. Is there a history of any medical conditions that may affect the applicant's binocular field of vision (central and/or peripheral)?	YES		NO	
8. Is there diplopia? (a) If **Yes**, is it controlled? If Y**es**, please give full details in the box provided	YES		NO	
9. Does the applicant, on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision that impairs their ability to drive?	YES		NO	
10. Does the applicant have any other ophthalmic conditions? If **Yes** to any of questions 7 – 10, please give full details in the box provided	YES		NO	
Details/additional information	**You must sign and date this section:** Name of examining doctor/optician (print): Signature of examining doctor/optician: Date of signature: Please provide your GOC or GMC number: Doctor/optometrist/optician's stamp:			

Applicant's Full Name: …… Date of birth: D D / M M / Y Y

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Part 2b – Medical Examination Report

Medical Assessment

Must be filled in by a doctor

Please check the applicant's identity before you proceed.

Please ensure that you fully examine the applicant and take the applicant's history.

1 Neurological disorders

Is there a history of, or evidence of, any neurological disorder?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 2** on page 5
1. Has the applicant had any form of seizure?	YES	NO
(a) Has the applicant had more than one attack?	YES	NO
(b) Please give date of first and last attack:	First attack ___ /___ /___	Last attack ___ /___ /___
(c) Is the applicant currently on anti-epileptic medication?	YES Please fill in current medication in **Section 8** on page 10	NO
(d) If no longer treated, please give date when treatment ended:	Treatment ended:	___ /___ /___
(e) Has the applicant had a brain scan?	YES Give details in **Section 6** on page 11	NO
(f) Has the applicant had an EEG?	YES	NO
If **Yes** to any of the above, please supply reports if available		
2. Stroke or TIA?	YES	NO
If yes, please give date:	___ /___ /___	
Has there been a **FULL** recovery?	YES	NO
Has a carotid ultrasound been undertaken?	YES	NO
If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	YES	NO
3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	YES	NO
4. Subarachnoid haemorrhage?	YES	NO
5. Serious traumatic brain injury within the last ten years?	YES	NO
6. Any form of brain tumour?	YES	NO
7. Other brain surgery or abnormality?	YES	NO
8. Chronic neurological disorders?	YES	NO
9. Parkinson's disease?	YES	NO
10. Is there a history of blackout or impaired consciousness within the last 5 years?	YES	NO
11. Does the applicant suffer from narcolepsy?	YES	NO

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2 Diabetes mellitus

Does the applicant have diabetes mellitus?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3** on page 6
1. Is the diabetes managed by: (a) Insulin? If **Yes**, please give date:	YES ___ /___ /___	NO
(b) If treated with insulin, are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)?	YES	NO Give details in **Section 6** on page 11
(c) Other injectable treatments?	YES	NO
(d) A Sulphonylurea or a Glinide?	YES	NO
(e) Oral hypoglycaemic agents and diet? If **Yes** to any of (a) – (e), please fill in current medication in **Section 8** on page 10	YES	NO
(f) Diet only?	YES	NO
2. (a) Does the applicant test blood glucose at least twice every day?	YES	NO
(b) Does the applicant test at times relevant to driving **(no more than 2 hours before the start of the first journey and every 2 hours while driving)?**	YES	NO
(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?	YES	NO
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	YES	NO
3. Is there any evidence of impaired awareness of hypoglycaemia?	YES	NO
4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	YES Give details in **Section 6** on page 11	NO
5. Is there evidence of: (a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	YES YES Give details in **Section 6** on page 11	NO NO
6. Has there been laser treatment or intra-vitreal treatment for retinopathy?	YES	NO
If **Yes**, please give date(s) of treatment:		

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3 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary heart disease?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3b** below
1. Has the applicant suffered from angina? If **Yes**, please give the date of the last known attack:	YES ___ /___ /___	NO
2. Acute coronary syndrome including myocardial infarction? If **Yes**, please give the date:	YES ___ /___ /___	NO
3. Coronary angioplasty (PCI)? If **Yes**, please give date of most recent intervention:	YES ___ /___ /___	NO
4. Coronary artery bypass graft surgery? If **Yes**, please give date:	YES ___ /___ /___	NO
5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?	YES	NO

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3c** on page 7
1. Has there been a **significant** disturbance of cardiac rhythm? i.e. sinoatrial disease, significant atrio-vernacular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years?	YES	NO
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	YES	NO
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted?	YES	NO
4. Has a pacemaker been implanted? If **Yes**: (a) Please give date of implantation: (b) Is the applicant free of the symptoms that caused the device to be fitted? (c) Does the applicant attend a pacemaker clinic regularly?	YES ___ /___ /___ YES YES	NO NO NO

c Peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3d** below
1. Peripheral arterial disease (excluding Buerger's disease)?	YES	NO
2. Does the applicant have claudication? If **Yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?	YES	NO
3. Aortic aneurysm? If **Yes**: (a) Site of aneurysm: (b) Has it been repaired successfully? (c) Is the transverse diameter **currently** > 5.5cm? If **No**, please provide latest measurement and date obtained:	YES Thoracic YES YES ……	NO Abdominal NO NO ___/___/___
4. Dissection of the aorta repaired successfully?	YES If **Yes**, please provide copies of all reports to include those dealing with any surgical treatment	NO
5. Is there a history of Marfan's disease?	YES If **Yes**, please provide relevant hospital notes	NO

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease?	YES Please answer **all** the questions below, give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3e** on page 8
1. Is there a history of congenital heart disease?	YES	NO
2. Is there a history of heart valve disease?	YES	NO
3. Is there a history of aortic stenosis?	YES If **Yes**, please provide relevant hospital notes	NO
4. Is there any history of embolism? (**not** pulmonary embolism)	YES	NO
5. Does the applicant currently have significant symptoms?	YES	NO
6. Has there been any progression since the last licence application? (if relevant)	YES	NO

e Cardiac other

Is there a history of, or evidence of, heart failure?	YES Please answer **all** questions and enclose relevant hospital notes	NO Go to **Section 3f** below
1. Established cardiomyopathy?	YES	NO
2. Has a left ventricular assist device (LVAD) been implanted?	YES	NO
3. A heart or heart/lung transplant?	YES	NO
4. Untreated atrial myxoma?	YES	NO

f Cardiac channelopathies

Is there a history of, or evidence of either of the following conditions?	YES If **Yes** to either, please give details in **Section 6** on page 11 and enclose relevant hospital notes	NO Go to **Section 3g** below
1. Brugada syndrome?	YES	NO
2. Long QT syndrome?	YES	NO

g Blood pressure

If resting blood pressure is 180mm Hg systolic or more and/or reading 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided:		
1. Please record today's **best resting** blood pressure reading:		
2. Is the applicant on anti-hypertensive treatment?	YES	NO
If **Yes**, please provide three previous readings with dates if available:	……	___/___/___
	……	___/___/___
	……	___/___/___
3. Is there a history of malignant hypertension?	YES If **Yes**, please provide details in **Section 6** on page 11 (including date of diagnosis and any treatment, etc.)	NO

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h Cardiac investigations

Have any cardiac investigations been undertaken or planned?	YES If **Yes**, please answer questions 1-6	NO Go to **Section 4** on page 10
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?	YES YES YES YES If **Yes** to (a), (b) or (c) please provide a copy of the relevant ECG report or comment at **Section 6** on page 11	NO NO NO NO
2. Has an exercise ECG been undertaken (or planned)? If **Yes**, please give date and give details in **Section 6** on page 11	YES ___ /___ /___ Please provide relevant reports if available	NO
3. Has an echocardiogram been undertaken (or planned)? (a) If **Yes**, please give date and give details in **Section 6** on page 11 (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?	YES ___/ ___/ ___ YES Please provide relevant reports if available	NO NO
4. Has a coronary angiogram been undertaken (or planned)? If **Yes**, please give date and give details in **Section 6** on page 11	YES ___ /___ /___ Please provide relevant reports if available	NO
5. Has a 24 hour ECG tape been undertaken (or planned)? If **Yes**, please give date and give details in **Section 6** on page 11	YES ___ /___ /___ Please provide relevant reports if available	NO
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? If **Yes**, please give date and give details in **Section 6** on page 11	YES ___ /___ /___ Please provide relevant reports if available	NO

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4 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years?	YES If **Yes** please answer **all** questions below	NO Go to **Section 5** below
1. Significant psychiatric disorder within the past 6 months?	YES	NO
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?	YES	NO
3. Dementia or cognitive impairment?	YES	NO
4. Persistent alcohol misuse in the past 12 months?	YES	NO
5. Alcohol dependence in the past 3 years?	YES	NO
6. Persistent drug misuse in the past 12 months?	YES	NO
7. Drug dependence in the past 3 years?	YES	NO
If **Yes** to any questions above, please provide full details in **Section 6** on page 11, including dates, period of stability and where appropriate consumption and frequency of use.		

5 General

All questions must be answered. If **Yes** to any, give full details in **Section 6** on page 11 and enclose relevant hospital notes		
1. Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?	YES	NO
If **Yes**, please give diagnosis:		
(a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:	Mild (AHI <15)	
	Moderate (AHI 15 – 29)	
	Severe (AHI >29)	
If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in **Section 6** on page 11	Not known	
(b) Please answer questions (i) to (vi) for **all** sleep conditions:		
(i) Date of diagnosis:	___ /___ /___	
(ii) Is it controlled successfully?	YES	NO
(iii) If **Yes**, please state treatment:		
(iv) Is applicant compliant with treatment?	YES	NO
(v) Please state period of control:		
(vi) Date of last review:	_____ / _____ / _____	
2. Is there **currently** any functional impairment that is likely to affect control of the vehicle?	YES	NO
3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	YES	NO
4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	YES	NO

Continued on next page

General (continued)

5. Is the applicant profoundly deaf? If **Yes**, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?	YES YES	NO NO
6. Does the applicant have a history of liver disease of any origin?	YES If **Yes**, please provide details in **Section 6** on page 11	NO
7. Is there a history of renal failure?	YES If **Yes**, please provide details in **Section 6** on page 11	NO
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	YES	NO
9. Does any medication currently taken cause the applicant side effects that could affect safe driving?	YES If **Yes**, please provide details of medication and symptoms in **Section 6** on page 11	NO
10. Does the applicant have any other medical condition that could affect safe driving?	YES If **Yes**, please provide details in **Section 6** on page 11	NO

6 Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

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7 Consultants' Details

Details of type of specialist(s)/consultants, including address.			
Consultant in:		Consultant in:	
Name:		Name:	
Address:		Address	
Date of last appointment:		Date of last appointment:	
Consultant in:		Consultant in:	
Name:		Name:	
Address:		Address	
Date of last appointment:		Date of last appointment:	

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)	
Medication:	Dosage:
Reason for taking:	
Medication:	Dosage:
Reason for taking:	
Medication:	Dosage:
Reason for taking:	
Medication:	Dosage:
Reason for taking:	
Medication:	Dosage:
Reason for taking:	

9 Additional information

Patient's Weight (kg)	
Height (cm)	
Details of smoking habits (if any)	
Number of alcohol units taken each week	

Applicant's Full Name: …… Date of birth: D D / M M / Y Y

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10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination.

Please ensure that all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside the UK.

Doctor's Name:			
Doctor's Address:			
Driver's Full Name:		Date of Birth:	
Driver's Full Address:			

I hereby certify that the information given by the applicant in the Part 1 Medical Questionnaire is accurate to the best of my knowledge.		Practice Stamp:	
Doctor's Signature:			
Date:			
The applicant meets group 2 medical standards applied by DVLA in relation to bus and lorry drivers and as such is considered fit/unfit to drive a hackney carriage vehicle or private hire vehicle. **Please tick or circle the FIT or UNFIT box to the right as appropriate.**		**FIT**	**UNFIT**
Additional comments:			