



MALDON DISTRICT
COUNCIL

Drivers medical questionnaire – Medical in Confidence

Name	Date of birth	Date of assessment
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Do you have, or have you ever had any of the following?

		YES	NO
1	Impairment of vision.	<input type="checkbox"/>	<input type="checkbox"/>
2	Difficulty seeing well enough to drive when there is glare or poor visibility such as fog.	<input type="checkbox"/>	<input type="checkbox"/>
3	Fits, epilepsy, fainting or blackouts.	<input type="checkbox"/>	<input type="checkbox"/>
4	Attacks of dizziness or vertigo.	<input type="checkbox"/>	<input type="checkbox"/>
5	Weakness, loss of sensation or clumsiness affecting part of your body.	<input type="checkbox"/>	<input type="checkbox"/>
6	Severe head injury or brain surgery.	<input type="checkbox"/>	<input type="checkbox"/>
7	Difficulty hearing normal conversation.	<input type="checkbox"/>	<input type="checkbox"/>
8	Trouble with your back or neck causing absence from work or a change in duties.	<input type="checkbox"/>	<input type="checkbox"/>
9	Any form of cancer.	<input type="checkbox"/>	<input type="checkbox"/>
10	Diabetes.	<input type="checkbox"/>	<input type="checkbox"/>
11	Psychiatric illness including depression or anxiety.	<input type="checkbox"/>	<input type="checkbox"/>
12	Dependency on or misuse of alcohol, drugs or other substances.	<input type="checkbox"/>	<input type="checkbox"/>
13	Disease of the heart or circulation including angina, heart attack or heart valve problems.	<input type="checkbox"/>	<input type="checkbox"/>
14	Abnormal heart rhythm or irregular heartbeat.	<input type="checkbox"/>	<input type="checkbox"/>
15	High blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>
16	Any serious medical condition that may result in you being a danger to yourself or others when driving.	<input type="checkbox"/>	<input type="checkbox"/>

List any medication that you are taking

If you answered yes to any question, please write any comments in this space
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