



Questionnaire to assess your Medical Fitness to Drive

If you are unsure of the answers, we advise you to discuss the form with your Doctor.

1. Please give the name of your medical condition or conditions.

2. Please give the name and dosage (the amount you take) of all the current medication taken by you **or** enclose a copy of your repeat prescription counterfoil. **(Continue overleaf if necessary.)**

Name of Medication	Dosage	Reason for Taking

3. Please give the date of your last and next appointment with your doctor or consultant:

Doctor

Consultant

DD	MM	YY

DD	MM	YY

Date of **last** appointment

Date of **next** appointment

- | | | | | |
|--|------------|--------------------------|-----------|--------------------------|
| 4. Does the medication make you drowsy or confused? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 5. Do you suffer from significant memory problems? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 6. Do you suffer from episodes of confusion? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 7. Do you need help from another person with your day to day living? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

If YES, please give details of how they help you. _____

NAME:	DOB:	REF:
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DRIVER NUMBER:

CG1 ONLINE

(Rev Feb 13)

8. In the past 12 months have you regularly misused alcohol? YES NO
9. In the past 12 months have you taken illicit drugs? YES NO
- 10a. Do you **need** to drive a vehicle fitted with special controls or automatic transmission? *If you answered NO to question 10a you DO NOT need to answer questions 10b and 10c.* YES NO
- 10b. Have you told us before that you need special controls or automatic transmission? YES NO
If you answered YES to question 10b please answer question 10c.
- 10c. Since your last licence was issued have you had any additional controls fitted to your vehicle? YES NO

NAME:	DOB:	REF:
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DRIVER NUMBER:



Note: please fill in and return all pages (1-4) of this medical questionnaire and consent/declaration. If you do not give us all the information we need including the full name, address and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0845 850 0095

Please keep this page (5) for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving

