

Assessing Fitness to Drive 2016  
Health Assessment for Commercial Vehicle Driver

**DRIVER HEALTH QUESTIONNAIRE**  
(to be completed by driver)

**Driver information:**

Surname:	Given name(s):
Address:	
Date of birth:	Phone:
Driver licence number:	State of issue:

**Employer information:**

Employer name:	
Address:	Phone:

**Instructions for completion:**

Please answer the questions by ticking the appropriate box. If you are not sure what a question means, leave the answer blank and the health professional will help you. The health professional will ask you additional questions during the assessment. On completion of the questionnaire you will be asked to sign a declaration to confirm the accuracy of your responses.

Please bring with you to the assessment:

- A list of current prescription, non-prescription and complementary medicines
- Glasses/contact lenses and hearing aids if you use them
- Disease management plans (e.g. sleep disorder management plan, diabetes management plan)

**Disclosure of health information:**

**Please read carefully and sign to indicate you understand how health information is reported, stored and accessed.**

The details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of whether you meet the medical criteria for driving a commercial vehicle. The examining health professional retains all detailed health documentation including your questionnaire responses and the completed record of clinical findings. The examining health professional will provide you with the report form to return to the requesting organisation indicating your fitness for duty classification. Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except when required by law.

You have the right to access your health records including those held by the examining health professional and the reports held by the requesting organisation.

**Driver's declaration**

I have read and understood the above statement concerning the health information provided in this document.

Signature of driver

Date

**Consent to contact treating health professionals**

I consent to the examining doctor contacting my treating health professionals to clarify aspects of my medical management.

Signature of driver

Date

**Questions:**

- |   |  |
|---|--|
| 1. Are you currently attending a health professional for any illness, injury or disability? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Are you taking any prescription, non-prescription or complementary medicines?            | <input type="checkbox"/> No <input type="checkbox"/> Yes |

If YES to Question 1 or 2 please provide brief details:

**Health professional's comments:**

**3. Do you suffer from or have you ever suffered from any of the following:**

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">3.1 High blood pressure</td> <td style="width: 20%; text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.2 Heart disease</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.3 Chest pain, angina</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.4 Any condition requiring heart surgery</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.5 Palpitations / irregular heartbeat</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.6 Abnormal shortness of breath</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.7 Diabetes</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.8 Head injury, spinal injury</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.9 Seizures, fits, convulsions, epilepsy</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.10 Blackouts or fainting</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> </table>	3.1 High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.2 Heart disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.3 Chest pain, angina	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.4 Any condition requiring heart surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.5 Palpitations / irregular heartbeat	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.6 Abnormal shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.7 Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.8 Head injury, spinal injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.9 Seizures, fits, convulsions, epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.10 Blackouts or fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">3.11 Stroke</td> <td style="width: 20%; text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.12 Dizziness, vertigo, problems with balance</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.13 Memory loss or difficulty with attention or concentration</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.14 Other neurological disorder</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.15 Neck, back or limb disorders</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.16 Double vision, difficulty seeing</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.17 Colour blindness</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.18 Hearing loss or deafness or had an ear operation or use a hearing aid</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> <tr> <td>3.19 A psychiatric illness or nervous disorder</td> <td style="text-align: right;"><input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> </table>	3.11 Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.12 Dizziness, vertigo, problems with balance	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.13 Memory loss or difficulty with attention or concentration	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.14 Other neurological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.15 Neck, back or limb disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.16 Double vision, difficulty seeing	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.17 Colour blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.18 Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/> No <input type="checkbox"/> Yes	3.19 A psychiatric illness or nervous disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
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**Health professional's comments:**

- |  |  |
|--|--|
| 4. Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason? (please describe). | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|--|--|

**Health professional's comments:**

**5. Sleep**

5.1 Have you ever been tested for a sleep disorder or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.2 Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**IN-CONFIDENCE WHEN COMPLETED**  
**THIS FORM SHOULD BE RETAINED BY THE EXAMINING HEALTH PROFESSIONAL**

5.3	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? <i>This refers to your usual way of life in recent times. If you haven't done some of these things recently try to work out how they would have affected you.</i>	would never doze off <b>(0)</b>	slight chance of dozing <b>(1)</b>	moderate chance of dozing <b>(2)</b>	high chance of dozing <b>(3)</b>
<b>a</b>	Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b</b>	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c</b>	Sitting inactive in a public place (e.g. a theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d</b>	As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>e</b>	Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>f</b>	Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>g</b>	Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>h</b>	In a car, while stopped for a few minutes in the traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Health professional's comments:**

<b>6. Alcohol</b>						
<b>6.1</b>	Have you ever sought assistance for alcohol or substance use issues?					<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>6.2</b>	<b>Please circle the answer that best describes your situation.</b>	<b>(0)</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>
<b>a</b>	How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>b</b>	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
<b>c</b>	How often do you have six or more drinks on one occasion?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>d</b>	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>e</b>	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>f</b>	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>g</b>	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>h</b>	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
<b>i</b>	Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year		Yes, during the last year	
<b>j</b>	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year		Yes, during the last year	

**Health professional's comments**

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**Other**

7. Do you currently use illicit drugs?  No  Yes
8. Do you use any drugs or medications not prescribed for you by your doctor?  No  Yes
9. Have you been in a vehicle crash since your last fitness to drive examination?  No  Yes

**Health professional's comments**

**Driver's declaration – accuracy and completeness of information provided**

To the best of my knowledge the answers given above are accurate and complete:

Signature of driver

Date

Signature of examining doctor

Date