

MEDICAL HISTORY FOR ASSESSING FITNESS TO DRIVE

Please fill in the form before the medical examination.
 You can complete any unclear sections during the examination.
 Please take the form with you to the medical examination.
 The form is entered into your patient documents and will not be sent to the police

Personal data	Personal identity code	Last name	First names
	Address	Postal code and town/city	
	Municipality of residence	Occupation (also before retirement)	

1. Do you have : - trouble seeing in daylight? - trouble seeing in twilight? - double vision (diplomia)?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
2. Have you been diagnosed with heart disease, cerebrovascular disease or a stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you have suspected or diagnosed memory disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you suffer from chronic insomnia or have you been diagnosed with sleep apnoea or some other sleep disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you have mental disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have a substance abuse problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you undergone a medical examination for dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you had epileptic seizures or other disturbances of consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you use a hearing aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has a doctor suspended your right to drive for health reasons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Have you ever fallen asleep while driving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

14. Length	Weight
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Circle the option that best describes your answer in questions 15-17

15. How often do you have beer, wine or other drinks containing alcohol? Try to also count the times when you drink only small amounts, e.g. a bottle of lager or a small glass of wine. 0. Never 1. Once a month or less often 2. 2-4 times a month 3. 2-3 times a week 4. 4 times a week or more often	16. How many units of alcohol do you have on a typical day when you are drinking? 0. 1-2 units 1. 3-4 units 2. 5-6 units 3. 7-9 units 4. 10 units or more One unit is: - a bottle of average-strength (4.7%) beer or cider (330ml) - a glass of low-alcohol wine (120ml) - a small glass of high-alcohol wine (80ml) - a single measure of spirits (40ml)	17. How often do you have six or more units on one occasion? 0. Never 1. Less than once a month 2. Once a month 3. Once a week 4. Daily or almost daily
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18. Have you used other narcotic substances than alcohol?
 Yes No

19. Have you had a medical examination in the past 3 years? Have you undergone operations or other medical procedures? Please specify where and why.

I give my consent for retrieving relevant information from the above-mentioned healthcare units for the assessment of driving competence.
 yes no Signature

20. List the medicines you are currently taking and their dosage (continue on separate sheet if necessary).

I declare that I have answered the questions honestly

Place and date	Signature
	Clarification of signature