Assessing fitness to drive 2022

Health Assessment for Commercial Vehicle Driver

DRIVER HEALTH QUESTIONNAIRE

(to be completed by driver)

Health assessment history:

Please note the date of your last fitness to drive assessment Date: ☐ Not applicable or not known

Driver information:

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

Employer information:

Employer:	
Address:	
Contact name:	Phone:
Contact email	

Instructions to driver:

Please answer the questions by ticking the appropriate box and providing details as requested. 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.

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)

On completion of the questionnaire, you will be asked to sign a declaration to confirm the accuracy of your responses. You will also be asked to provide your consent if the health professional requests to make contact with your treating health professional(s) to help clarify your medical management as required to determine fitness to drive.

Management of your health information:

Please read carefully and sign the declaration on the last page to indicate you understand how health information is reported, stored and accessed.

Your health information may only be collected and disclosed for the purpose of managing your fitness to drive a commercial vehicle. This means that details of your health assessment will remain confidential and will only be reported to the requesting organisation in terms of your fitness to drive.

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. If you are assessed as unfit to drive, the examining doctor will advise you and contact the requesting organisation straight away.

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.

Questions:

1.	Are you currently attending a health professional for any illness, injury or disability?	☐ No ☐ Yes
2.	Are you taking any prescription, non-prescription or complementary medicines?	☐ No ☐ Yes

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

Health professional comments:

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

3.1	High blood pressure	☐ No ☐ Yes	**3.11**	Stroke	☐ No ☐ Yes
3.2	Heart disease	☐ No ☐ Yes	**3.12**	Dizziness, vertigo, problems with balance	☐ No ☐ Yes
3.3	Chest pain, angina	☐ No ☐ Yes	**3.13**	Memory loss or difficulty with attention or concentration	☐ No ☐ Yes
3.4	Any condition requiring heart surgery	☐ No ☐ Yes	**3.14**	Other neurological or neurodevelopmental disorder	☐ No ☐ Yes
3.5	Palpitations / irregular heartbeat	☐ No ☐ Yes	**3.15**	Neck, back or limb disorders	☐ No ☐ Yes
3.6	Abnormal shortness of breath	☐ No ☐ Yes	**3.16**	Double vision, difficulty seeing	☐ No ☐ Yes
3.7	Diabetes	☐ No ☐ Yes	**3.17**	Colour blindness	☐ No ☐ Yes
3.8	Head injury, spinal injury	☐ No ☐ Yes	**3.18**	Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No ☐ Yes
3.9	Seizures, fits, convulsions, epilepsy	☐ No ☐ Yes	**3.19**	A psychiatric illness or nervous disorder	☐ No ☐ Yes
3.10	Blackouts or fainting	☐ No ☐ Yes			

Health professional comments:

4.	Have you ever had any other serious injury, illness, disability, operation or accident or been in hospital for any reason?	☐ No ☐ Yes

Please describe:

Health professional 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?	☐ No ☐ Yes
5.2	Are you aware or have you been told that you snore loudly?	☐ No ☐ Yes
5.3	Has anyone told you that your breathing stops or is disrupted by episodes of choking during your sleep?	☐ No ☐ Yes

		would never doze off **(0)**	slight chance of dozing **(1)**	moderate chance of dozing **(2)**	high chance of dozing **(3)**
5.4	How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *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.*				
a	Sitting and reading	☐	☐	☐	☐
b	Watching TV	☐	☐	☐	☐
c	Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
d	As a passenger in a car for an hour without a break	☐	☐	☐	☐
e	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f	Sitting and talking to someone	☐	☐	☐	☐
g	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
h	In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Health professional comments:

6. Alcohol and other drugs

6.1	Have you ever sought assistance for alcohol or substance use issues?	☐ No ☐ Yes

	6.2 Please circle the answer that best describes your situation.	**(0)**	**(1)**	**(2)**	**(3)**	**(4)**
a	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 + times per week ☐
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 ☐
c	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 + times per week ☐
d	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 + times per week ☐
e	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 + times per week ☐
f	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 + times per week ☐
g	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 + times per week ☐
h	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 + times per week ☐
i	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 ☐

		No	Yes, but not in the last year	Yes, during the last year
j	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	☐	☐	☐

Health professional comments:

Other drugs

6.3	Do you currently use illicit drugs?	☐ No ☐ Yes
6.4	Do you use any drugs or medications not prescribed for you by your doctor?	☐ No ☐ Yes

Please describe:

6.5	Have you tested positive for drugs or alcohol in the period since your last assessment?	☐ No ☐ Yes

Health professional comments:

7.	Have you been in a vehicle crash or had a near miss since your last fitness to drive examination?	☐ No ☐ Yes

Health professional 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

Driver's declaration

I have read and understood the 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