PATIENT QUESTIONNAIRE

Name

Address

Please answer the questions by ticking the correct box. If you are not sure, leave the question blank and ask your doctor what it means. The doctor will ask you additional questions during the examination.

		No	Yes
1.	Are you currently being treated by a doctor for any illness or injury?	☐	☐
2.	Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)? *(Please take any medications with you to show the doctor)*	☐	☐
3.	Have you ever had, or been told by a doctor that you had any of the following?		
3.1	High blood pressure	☐	☐
3.2	Heart disease	☐	☐
3.3	Chest pain, angina	☐	☐
3.4	Any condition requiring heart surgery	☐	☐
3.5	Palpitations/irregular heartbeat	☐	☐
3.6	Abnormal shortness of breath	☐	☐
3.7	Head injury, spinal injury	☐	☐
3.8	Seizures, fits, convulsions, epilepsy	☐	☐
3.9	Blackouts, fainting	☐	☐
3.10	Stroke	☐	☐
3.11	Dizziness, vertigo, problems with balance	☐	☐
3.12	Double vision, difficulty seeing	☐	☐
3.13	Colour blindness	☐	☐
3.14	Kidney disease	☐	☐
3.15	Diabetes	☐	☐
3.16	Neck, back or limb disorders	☐	☐
3.17	Hearing loss or deafness or had an ear operation or use a hearing aid	☐	☐
3.18	Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐	☐
3.19	Have you ever had, or been told by a doctor that you had a psychiatric illness, or nervous disorder?	☐	☐
3.20	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	☐	☐
4.1	Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? *This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.*

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you put a number (0 to 3) in each of the 8 boxes.

Situation	**Chance of dozing (0–3)**
Sitting and reading	☐
Watching TV	☐
Sitting, inactive in a public place (e.g. a theatre or meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in the traffic	☐

PATIENT QUESTIONNAIRE (continued)

5. ***Please tick the answer that is correct for you:***

5.1 How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Monthly
- ☐ Two to four times a month
- ☐ Two to three times a week
- ☐ Four or more times a week

5.2 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

5.3 How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.4 How often during the last year have you found that you were not able to stop drinking once you had started?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.5 How often during the last year have you failed to do what was normally expected from you because of drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.6 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 ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.7 How often during the last year have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5.9 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

5.10 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

		No	**Yes**
6.	Do you use illicit drugs?	☐	☐
7.	Do you use any drugs or medications not prescribed for you by a doctor?	☐	☐
8.	Have you been in a vehicle crash since your last licence examination?	☐	☐

If Yes, please give details: _____

_____

Applicant's Declaration ***(in presence of health professional)***:

I, _____

(Print Name)

– certify that to the best of my knowledge the above information supplied by me is true and correct

Signature: _____ Date: / /

IMPORTANT

For privacy reasons, the completed Patient Questionnaire must not be returned to the licensing authority. Medical information relevant to driver licensing should be included on the Medical Certificate (in the case of Licensing Authority-initiated examinations) or on the Medical Condition Notification Form (for assessments made in the course of patient treatment).