Drivers Health Questionnaire

Office Use Only

These questions have been designed to give a clear picture of your present health status and to identify any potential health problems for the future. All your answers are confidential and will only be seen by the health assessor. However, should a significant health problem be detected requiring medical investigation, you will be given a letter to take to your GP.

Name:

Date of Birth:

Company Name:

Job Title:

E-mail:

Hours of work per week:

Approximate monthly work mileage:

What vehicle do you drive for work?

Own Car ☐

Company Car ☐

Company Van/Truck ☐

Personal Medical History

Please put ☑ for YES and ☒ for NO. Leave blank if unsure.
If you answer YES, please give brief details in Supplementary Information

1) Do you or have you ever suffered from any of the following cardiovascular diseases or disorders?

Heart Attack ☐

Angina ☐

Recurrent Chest Pain ☐

Palpitations ☐

High Blood Pressure ☐

Heart Murmur ☐

Rheumatic Fever ☐

Irregular Pulse ☐

Valve Disease ☐

2) Do you or have you ever suffered from any of the following diseases or disorders of the brain?

Stroke ☐

Dizziness ☐

Epilepsy ☐

Convulsions ☐

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3) **Do you or have you ever suffered from any of the following nervous disorders?**

Anxiety ☐ Depression ☐ Stress ☐

4) **Do you or have you ever suffered from any of the following respiratory diseases or disorders?**

Asthma ☐ Chronic Bronchitis ☐ Tuberculosis ☐ Coughing Up Blood ☐

5) **Do you or have you ever suffered from any of the following endocrine conditions?**

Diabetes Type 1 ☐ Diabetes Type 2 ☐ Glandular Disease ☐ Thyroid Disorder ☐

6) **Have you ever been diagnosed as having any form of the following?**

Cancer ☐ Tumour ☐ Cyst ☐ Lump ☐

If yes, where in the body? ....

7) **Have you ever undergone a surgical operation?** ☐ If yes, give details below

8) **Have you ever suffered from any serious injury requiring hospital treatment?**

☐ If yes, give details below

Supplementary Information *Please insert question number and relevant details in the space provided*	
Question Number	**Brief Details ie. condition, dates, investigations, duration of treatment etc**

Supplementary Information continued *Please insert question number and relevant details in the space provided*	
Question Number	**Brief Details ie. condition, dates, investigations, duration of treatment etc**

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Medication: Please state the medicines you are currently taking

Name of Medicine	Dosage	Times taken per day
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....

Nutritional or Herbal Supplements: Please state any you are currently taking

Name of Supplement	Dosage	Times taken per day
....	....	....
....	....	....
....	....	....
....	....	....
....	....	....

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Smoking Status:

Do you smoke? ☐ If yes, please state: Cigarettes ☐ Cigars ☐ Pipe ☐ Other ☐

How many a day? ☐ Do you intend to give up smoking soon? ☐

If you do not smoke now, have you ever smoked? ☐

If yes, please state: Cigarettes ☐ Cigars ☐ Pipe ☐ Other ☐

When did you stop smoking? ☐

Alcohol Status:

One unit = ½ pint of Beer/Cider, a small glass of wine, or a pub measure of spirits

What is your average weekly consumption of alcohol in units? ☐

If <1, how many units a month? ☐ Did you regularly drink more in the past? ☐

Do you drink more than 2 units a day? Never ☐ Occasionally ☐ x1/week or more ☐ Every Day ☐

Exercise:

Do you have a regular exercise routine? ☐

Do you do at least ½ hour of brisk exercise five times a week? ☐

If not, how much exercise do you do in a week? ....

What type(s) of exercise/activity do you do? ....

Do you have a sedentary job? ☐

Do you often drive short distances rather than walk? ☐

Do you normally take the lift or escalator rather than the stairs? ☐

Do you have a disability that prevents you from exercising? ☐

Do you find time to relax each day? ☐

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Vision History:

When did you last visit an optician? [ ]

Do you wear glasses? [ ] If yes, what is your visual impairment?

Short-Sight [ ] Long-Sight [ ] Other [ ]

If Other, please give details ....

....

Do you wear contact lenses? [ ] If yes, what is your visual impairment?

Short-Sight [ ] Long-Sight [ ] Other [ ]

If Other, please give details ....

....

Family History:

Have close members of your family suffered from any of the following diseases or disorders?
Please put **M** for mother, **F** for father, **S** for sister or **B** for brother.

Diabetes Type 1 (Insulin dependent) [ ] Diabetes Type 2 (Non-Insulin dependent) [ ]

Stroke [ ] Heart Attack [ ] High Blood Pressure [ ] High Cholesterol [ ]

Respiratory Disease [ ] Glaucoma [ ] Cancer [ ]

If yes, where is/was the cancer? ....

Are both your parents still alive? [ ] If no, what age did they die? **M** .... **F** ....

What caused their death?

M ....

F ....

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Physical Assessment:

Details to be entered by Nurse Consultant

Urinalysis: **Albumin** ☐ **Glucose** ☐ **Blood** ☐ **pH** ☐

Height: .... **Weight:** .... **Body Mass Index:** ....

Waist: .... **Hip:** .... **Waist/Hip Ratio (W÷H):** ....

Blood Pressure: .... **2nd Reading if >140/90:** ....

Pulse Pressure: .... **Pulse:** .... **Regular/Irregular:** ....

PulmoLife Readings

1) FEV1 .... **Percentage:** .... **Pulmonary Age:** ....

Peak Flow: 1) .... 2) .... 3) ....

Body Fat Ratio: ....

CardioCheck Readings

1) PPT ....ms; **RI** ....%; **SI Normal Range** ....; **SI** ....m/s; **VA** ....

2) PPT ....ms; **RI** ....%; **SI Normal Range** ....; **SI** ....m/s; **VA** ....

Recommendations:

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