



**IMPORTANT:** Please answer the questions in **BLOCK CAPITAL** letters using **BLACK INK**.  
Failure to provide full information for yourself, GP or consultant may result in your case being delayed.

**PART A: About you**

**Current driving licence details**

**Title:** \_\_\_\_\_ **Full name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Contact number:** \_\_\_\_\_

**Change of details**

If you have changed your contact information (address, name, email or contact number) since we last corresponded with you, please provide the **NEW** details in the box below.


**PART B: Healthcare professional for your condition**

**GP details**

**GP name:**

**Surgery name:**

**Address:**

**Town:**

**Postcode:**

**Contact number:**

**Email:**

**Date last seen for this condition:**

**Consultant details**

**Consultant name:**

**Speciality:**  **Department:**

**Hospital name:**

**Address:**

**Town:**

**Postcode:**

**Contact number:**

**Email:**

**Date last seen for this condition:**



# Medical questionnaire – diabetes

1 Please tell us how your diabetes is treated. Put **X** in all boxes that apply.

a) Insulin   
Go to Q2

b) Sulphonylurea or Glinide (S&G) tablets   
Go to Q3

c) Any other treatment:

- tablets, such as Metformin or Dapagliflozin
- non-insulin injections
- pancreas transplant
- islet cell transplant
- diet or other lifestyle changes

**If ONLY boxes in 'c' are ticked go to Q8**

**If you are unsure what medication you are taking, you should discuss this with your healthcare professional.**

Below is a list of Sulphonylurea and Glinide – it is not an exhaustive list.

**Sulphonylurea**

- Tolbutamide
- Chlorpropamide
- Gliclazide also known as Zicron, Diamicon or Glydex
- Glipizide Modified Release also known as Dacadis MR, Diamicon MR, Edicil MR, Lamzarin MR, Nazdol, Ziclaseg MR, Laaglyda MR
- Glibenclamide also known as Amglidia or Euglucon
- Glipizide also known as Minodab
- Glimepiride also known as Amaryl

**Glinide**

- Repaglinide also known as Enyglid or Prandin
- Nateglinide also known as Starlix

2 Do you check your blood glucose (sugar) levels? Yes  No

3 Do you understand the warning signs of low blood glucose (hypoglycaemia)?  
Yes  No  For information on symptoms of low blood glucose see table below:

Early warning signs of low blood glucose include:		
• anxiety	• fast pulse or palpitations	• feeling hungry
• sweating	• shakiness or trembling	• tingling lips
If you don't treat this, it may result in more severe symptoms such as:		
• confusion	• difficulty concentrating	• slurred speech
• disorderly or irrational behaviour which may be mistaken for drunkenness		
<b>If left untreated this may lead to unconsciousness</b>		

## DIAB1

4 Do you get warning signs of low blood glucose?

Never had episodes of low blood glucose  **Go to Q7**

Yes, I get warning signs  No, I don't get warning signs

**Warning signs will make you aware of when an episode of low blood glucose is happening**

5 Have you had any severe episodes of low blood glucose, whilst awake, in the last 12 months?

Yes  **No  Go to Q7**

**Severe means an episode of low blood glucose needing help from another person.**

a) Were you driving when having a severe episode? Yes  No

b) If **yes**, tell us the date of this severe episode: 

DD	MM	YY

6 Have you had 2 or more episodes of low blood glucose in the last 12 months where you needed help?

Yes  **No  Go to Q7**

**Do not count episodes where you were given help but you could have helped yourself.**

a) If **yes**, did any of these episodes happen in the last 3 months?

Yes  No

7 Do you agree to monitor your blood glucose levels at times relevant to driving?

Yes  No

8 Have you had any treatment for diabetic related issues affecting both eyes, or the remaining eye if you only have sight in one eye?

**For example, laser treatment or eye surgery.**

Yes  **No  Go to Q9**

a) If **yes**, tell us the date of your last treatment: 

DD	MM	YY

9 As a result of your diabetes, do you have any problems with your limbs that affect your ability to control your vehicle safely?

Yes  **No  If no, do not complete the rest of the form**

## DIAB1

a) As a result of this condition, do you have to drive a vehicle with special controls?

Yes  No

b) If yes, please tell us of any modifications that you need to drive a car:

- transmission (10)
- clutch (15)
- braking system (20)
- accelerator system (25)
- pedal adaptations and safeguards (31)
- combined service brake and accelerator systems (32)
- combined service brake, accelerator and steering systems (33)
- control layouts (35)
- steering (40)
- rear view mirror (42)
- driver seat (43)

If yes, please tell us of any modifications that you need to drive a motorcycle, moped or tricycle:

- single operated brake (44.01)
- adapted front wheel brake (44.02)
- adapted rear wheel brake (44.03)
- adjusted accelerator (44.04)
- adjusted manual transmission and clutch (44.05)
- adjusted rear view mirror (44.06)
- adjusted commands (light, indicators etc) (44.07)
- seat height (allows the driver to have 2 feet on the surface at once and balance the wheel when stopping/standing) (44.08)
- adapted footrest (44.11)
- adapted hand grip (44.12)
- motorcycle with sidecar only (45)

10 As a result of your health condition, have you been told that you can only drive a vehicle with automatic gears? Do not mark 'Yes' if you drive a vehicle with automatic gears by choice.

Yes  No

**Applicant’s authorisation**

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

**Important information about fitness to drive**

- As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State’s Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at [www.gov.uk/dvla/privacy-policy](http://www.gov.uk/dvla/privacy-policy)

**This section must NOT be altered in any way.**

**Declaration**

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport’s Honorary Medical Advisory panel members.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorise the Secretary of State to correspond with medical professionals by email.**      Yes       No

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes. If not, DVLA will continue to contact you by post.      **Email**       **SMS (text)**

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you’ll be contacted by post.

**Email**       **SMS (text)**



Driver & Vehicle  
Licensing  
Agency

**Note:** there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

Please use the contact details below to return your completed medical questionnaire to the **Drivers Medical Group**.

**By post:**

Drivers Medical Group  
DVLA  
Swansea  
SA99 1DF

**By email:**

[eftd@dvla.gov.uk](mailto:eftd@dvla.gov.uk)

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