islands
taking care of tomorrow

MOTOR INSURANCE - GENERAL MEDICAL QUESTIONNAIRE

TO BE COMPLETED BY USUAL MEDICAL PRACTITIONER

Name: Policy Number:

Address: (In full)

Post Code: Date of Birth: DD/MM/YY

I certify that I have today examined the above named and that my findings are as follows:

Blood Pressure: ◯ High ◯ Low ◯ Normal

Vision: ◯ Good ◯ Poor* ◯ Satisfactory

*If poor, is sight corrected by the wearing of spectacles? **Yes** ☐ **No** ☐

Joint Movement: (a) Head Rotation:

(b) Upper Limb Joints:

(c) Lower Limb Joints:

Hearing: ◯ Good ◯ Poor* ◯ Satisfactory

*If poor, is hearing corrected by a hearing aid? **Yes** ☐ **No** ☐

Recent Medical History:

Nature of Complaint / Illness / Disability

a) Degree of Severity:

b) Effect on Everyday Life:

(c) Drugs Taken, Dosage and Possible Effects:

(d) Anticipated Period of Medication and Prognosis

(e) Any Other Significant Findings

I consider the above named *is/is not fit to drive a motor vehicle on the public highway.
I have advised the applicant accordingly.

Signature: _____ Date: _____

Qualifications: _____