

MEDICAL REPORT

CLIENT : _____
POLICY NUMBER : _____
AGE : _____

The following must be completed by a medical practitioner in respect of the above mentioned client

How long have you been attending this client: _____

BLOOD PRESSURE

Reading: _____
Is the client on medication: _____
If yes, please give details: _____

EYE SIGHT

Excellent Good Poor

Comments: _____

Does the client wear spectacles/ contact lenses: _____
If yes please state the date of last examination: _____
Details of the person who prescribed them: _____

HEARING

Please indicate distance tested: _____
Comments: _____

HEART

Comments: _____

Are the reflexes of the knees normal: _____
If no, please give details: _____

PHYSICAL IRREGULARITIES AND GENERAL FITNESS:

Comments: _____

Do you think the client is physically competent to drive a motor vehicle on a public road? _____

Does the client suffer from epilepsy; if yes, is he /she on medication? _____

DATE: _____

DOCTOR'S SIGNATURE AND STAMP: _____