

HARRY SHAW – CITY CRUISER

MILL HOUSE, MILL LANE, BINLEY, COVENTRY CV3 2DU
TEL 024 76 608440 FAX 024 76 608465

PERSONAL DETAILS

SURNAME

FORENAMES

HOME ADDRESS

..... POST CODE

PHONE NUMBER MOBILE NUMBER

NATIONALITY DATE OF BIRTH

N I NUMBER

DRIVING LICENCE No.

PASSPORT No.

JOB TITLE COMMENCEMENT DATE

NAME OF BANK

BRANCH ADDRESS

POSTCODE

ACCOUNT NUMBER SORT CODE

ACCOUNT IN NAME(S) OF

IN THE EVENT OF EMERGENCY, PLEASE GIVE DETAILS OF WHO WE SHOULD CONTACT

CONTACT NAME

ADDRESS

POSTCODE

HOME PHONE WORK PHONE

MOBILE PHONE

I confirm that the above details are correct as of the date given below.

Signature Date

MEDICAL QUESTIONNAIRE

(In confidence)

PLEASE ANSWER ALL QUESTIONS AS TRUTHFULLY AS POSSIBLE (AS APPLICABLE)

HAVE YOU EVER HAD, OR DO YOU AT PRESENT SUFFER FROM ANY OF THESE CONDITIONS?

- | | | |
|---|-----|----|
| (1) Fainting, Blackouts, Giddiness, Epilepsy or Fits of any kind | Yes | No |
| (2) Heart Condition or Operation, eg Rheumatic Fever or Angina | Yes | No |
| (3) Raised Blood Pressure or Stroke | Yes | No |
| (4) Tuberculosis | Yes | No |
| (5) Asthma, Bronchitis | Yes | No |
| (6) Mental Illness, Depression, Anxiety or Nervous Disability | Yes | No |
| (7) Dermatitis or any other Skin Disease | Yes | No |
| (8) Gastric Disorder, Stomach Trouble or Ulcers | Yes | No |
| (9) Rheumatism or Joint Trouble | Yes | No |
| (10) Back Pain, Disc Trouble or Sciatica | Yes | No |
| (11) Diabetes controlled by insulin or tablets | Yes | No |
| (12) Any Visual problems affecting either or both eyes | Yes | No |
| (13) Do you need to wear glasses/corrective lenses when driving? | Yes | No |
| (14) Chronic Headaches, Migraine or Hay Fever | Yes | No |
| (15) Any Ear Disease, Loss of Hearing or Perforation of Ear Drums | Yes | No |
| (16) Any serious accident or injury | Yes | No |
| (17) Continuing/Permanent Difficulty in the use of your arms or legs which affects your ability to control a vehicle safely | Yes | No |
| (18) Have you been dependent on or misused alcohol, illicit drugs or chemical substances in the past 3 years? | Yes | No |
| (19) A Chest X-Ray, If yes, when? | Yes | No |
| (20) Any other illness | Yes | No |
| (21) Have you been in hospital for an operation, medical treatment or attended as an outpatient for investigations in the last 5 years? | Yes | No |
| (22) Are you at present having any injections or taking any medication? | Yes | No |
| (23) Have you ever been refused insurance due to medical reasons? | Yes | No |
| (24) Are you a registered disabled person, if yes please give details below? | Yes | No |