D3

# COMMONWEALTH OF DOMINICA

## Ministry of Finance

### Citizenship by Investment Unit

## D3. MEDICAL QUESTIONNAIRE

This Medical Questionnaire is to be completed in English by a Registered Medical Practitioner.
Any additional information can be submitted on a separate sheet of paper. The Medical Practitioner must ask for evidence of identification (such as a passport).

| | | | |
|---|---|---|---|
| Full Name | | | |
| Residential Address | | | |
| Country of Residence | | | |
| Date of Birth | | Gender | M / F |
| Passport Number / National ID | | Date and place of issue | |
| Occupation | | Height (cm) | |
| Marital Status | | Weight (kg) | |
| Email Address | | | |

## PART A: Statement of Health

The Medical Examiner is requested to ask the following questions or to review them if they have been answered previously. Give details and dates if any of the questions below are answered with "Yes".

1. Do you currently have any health problems? Yes ☐ No ☐

2. Have you ever been hospitalised? Yes ☐ No ☐

3. Have you visited a doctor in the last three (3) years? Yes ☐ No ☐

4. Do you suffer from or have you ever suffered from any of the following

a) Tuberculosis Yes ☐ No ☐

b) Leprosy Yes ☐ No ☐

c) Hepititis (specify type) Yes ☐ No ☐

d) Typhoid, dysentery or any other infectious or communicable diseases Yes ☐ No ☐

e) AIDS or AIDS related conditions, any Immune Deficiency Syndrome Yes ☐ No ☐

f) Genetic or Familial Disorders Yes ☐ No ☐

g) Deafness or Chronic Ear Disease Yes ☐ No ☐

h) Blindness or Eye Disease Yes ☐ No ☐

i) Any cancerous disease: benign / malignant Yes ☐ No ☐

j) Headache, migraine, epilepsy or dizziness Yes ☐ No ☐

k) Nervous or mental illness or disorders Yes ☐ No ☐

l) Any allergies, asthma or pulmonary disease Yes ☐ No ☐

m) Cardiovascular diseases, arterial hypertension Yes ☐ No ☐

n) Liver, stomach or intestinal diseases Yes ☐ No ☐

o) Typhoid, dysentery or any other infectious or communicable diseases Yes ☐ No ☐

p) Urinary tract disease Yes ☐ No ☐

q) Venereal diseases Yes ☐ No ☐

r) Rheumatism, Muscle, Joint or bone diseases Yes ☐ No ☐

s) Skin diseases Yes ☐ No ☐

t) Cosmetic operations Yes ☐ No ☐

u) Any other illness or disorder Yes ☐ No ☐

If "Yes" to any of the above, please give details and dates.

## Part B: Medical Examination

If "Yes" to any of the below, please give details and dates.

5. Skin - Are there any signs of skin disease? Yes ☐ No ☐

6. Respiratory System - Any signs of abnormalities, (Including nose and lungs)? Yes ☐ No ☐

7. Cardiovascular System - Any signs of abnormalities, (Including pulse, blood pressure, heart murmurs)? Yes ☐ No ☐

8. Digestive Organs and abdomen - Any signs of abnormalities? Yes ☐ No ☐

9. Nervous System and sense organs - Any signs of abnormalities? Yes ☐ No ☐

10. Urogenital Organs - Any signs of abnormalities? Yes ☐ No ☐

Urinalysis: Protein | Sugar | Sediment

11. Musculoskeletal System - Any signs of abnormalities? Yes ☐ No ☐

12. Endocrine System - Any signs of abnormalities, including thyroid? Yes ☐ No ☐

13. Various - Any signs of abnormalities? Yes ☐ No ☐

14. Final Evaluation

15. Comments

**Important:** Medical Examiner must attach the original results of the following:

i) HIV test for all applicants over 12 years old

ii) Routine blood and urine test

iii) Immunization schedule against the following:

- Diphtheria
- Tetanus
- Hepatitis

## Part C: Medical examiner's details and declaration

Full Name of Medical Examiner

Organisation Address

Telephone No.

Fax No.

Email Address

I, the Medical Examiner, certify that I have identified, questioned and examined the applicant and answered all of the questions and supplied all of the information to the best of my knowledge and in good faith.

Date of Examination

Signature of Medical Examiner

Place of Examination

Examiner's designation / qualification

Stamp of Medical Examiner

Examiner's license number or certification