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

Place of Examination

Examiner's designation / qualification

Examiner's license number or certification

Signature of Medical Examiner

Stamp of Medical Examiner