



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	<input type="text"/>		
Residential Address	<input type="text"/>		
Country of Residence	<input type="text"/>		
Date of Birth	<input type="text"/>	Gender	<input type="text" value="M"/> <input type="text" value="F"/>
Passport Number / National ID	<input type="text"/>	Date and place of issue	<input type="text"/>
Occupation	<input type="text"/>	Height (cm)	<input type="text"/>
Marital Status	<input type="text"/>	Weight (kg)	<input type="text"/>
Email Address	<input type="text"/>		

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 <input type="checkbox"/> | No <input type="checkbox"/> | l) Any allergies, asthma or pulmonary disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Leprosy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | m) Cardiovascular diseases, arterial hypertension | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Hepatitis (specify type) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | n) Liver, stomach or intestinal diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Typhoid, dysentery or any other infectious or communicable diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> | o) Typhoid, dysentery or any other infectious or communicable diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) AIDS or AIDS related conditions, any Immune Deficiency Syndrome | Yes <input type="checkbox"/> | No <input type="checkbox"/> | p) Urinary tract disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) Genetic or Familial Disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> | q) Venereal diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) Deafness or Chronic Ear Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | r) Rheumatism, Muscle, Joint or bone diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h) Blindness or Eye Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | s) Skin diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i) Any cancerous disease: benign / malignant | Yes <input type="checkbox"/> | No <input type="checkbox"/> | t) Cosmetic operations | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j) Headache, migraine, epilepsy or dizziness | Yes <input type="checkbox"/> | No <input type="checkbox"/> | u) Any other illness or disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k) Nervous or mental illness or disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

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