

## COMMONWEALTH OF DOMINICA

## **Ministry of Finance**

Citizenship by Investment Unit

	D3. MEDICAL QUESTIONNAIRE  ionnaire is to be completed in English by a Registered Medical Practitioner.  ormation can be submitted on a separate sheet of paper. The Medical Practitioner must ask for cation (such as a passport).								
Any additional information	n can be submitted on a separate				ust a	sk for			
Full Name									
Residential Address									
Country of Residence									
Date of Birth		Gender	Gender			F			
Passport Number / National ID		Date and place of issue							
Occupation		Height (cm)							
Marital Status		Weight (kg)							
Email Address									
PART A: Statement	of Health equested to ask the following que	ections or to review th	em if they	have been	212674	ered			
	dates if any of the questions belo		•	nave been	a115 vv	ereu			
1. Do you currently have an	ıy health problems?	Yes	No						
2. Have you ever been hosp	vitalised?	Yes	No						

D3. Medical Questionnaire | © 2014 Government of Dominica |

3. Have you visited a doctor in the last three (3) years?

Yes

No 🗌

4. Do you suffer from or have you ever	r suffered	from any o	of the following		
a) Tuberculosis	Yes	No 🗌	Any allergies, asthma or	Yes	No 🗌
b) Leprosy	Yes	No 🗌	pulmonary disease		
c) Hepititis (specify type)	Yes	No 🗌	m)Cardiovascular diseases, arterial hypertension	Yes	No 🗌
d) Typhoid, dysentery or any other infectious or communicable diseases	Yes	No	n) Liver, stomach or intestinal diseases	Yes	No 🗌
e) AIDS or AIDS related conditions, any Immune Deficiency Syndrome	Yes	No 🗌	o) Typhoid, dysentery or any other infectious or communicable diseases	Yes	No 🗌
f) Genetic or Familial Disorders	Yes	No	p) Urinary tract disease	Yes	No 🗌
g) Deafness or Chronic Ear Disease	Yes	No	q) Venereal diseases	Yes	No 🗌
h) Blindness or Eye Disease	Yes	No	r) Rheumatism, Muscle, Joint or bone		_
<ul><li>i) Any cancerous disease: benign / malignant</li></ul>	Yes	No 🗌	diseases	Yes	No
j) Headache, migraine, epilepsy			s) Skin diseases	Yes	No 🗌
or dizziness	Yes	No	t) Cosmetic operations	Yes	No 🗌
k) Nervous or mental illness or disorders	Yes	No 🗌	u) Any other illness or disorder	Yes	No 🗌
If "Yes" to any of the above, please give	e details ar	nd dates			
Part B: Medical Examination If "Yes" to any of the below, please give 5. Skin - Are there any signs of skin di	e details ar	nd dates.		Yes	No 🗌
, 0					
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)?					No
8. Digestive Organs and abdomen - Any signs of abnormalities?					No [
	, 0	-			
9. Nervous System and sense organs - Any signs of abnormalities?					No 🗌

CTrustGlobal.com

10. Urogenital Org	ans - Any signs of abno	rmalities?				Yes	] :	No 🗌
Urinalysis:	Protein		Sugar		Sediment			
11 Musculoskalata	1 System Any signs of	ahn armaliti as?				Vac [		No.
11. Wiusculoskeieta	l System - Any signs of	abilormancies:				Yes		No
10 Feel and a Cont	A					v. [		N. $\square$
12. Endocrine Syste	12. Endocrine System - Any signs of abnormalities, including thyroid?					Yes _		No
13. Various - Any s	signs of abnormalities?					Yes [		No
14. Final Evaluation	1							
15. Comments								
15. Comments								
i) F	aminer must attach the orig HIV test for all applicants ov Coutine blood and urine test	er 12 years old	ollowing:					
	mmunization schedule again Diphtheria • Tetanus	_	is					
Full Name of Medical	al examiner's deta	ails and decl	aration					
Examiner Organisation Address			Telephone N	о.				
Organisation Address			Fax No.					
			Email Addre	SS				
	er, certify that I have identifi to the best of my knowledge		examined the appl	icant and answered	l all of the q	uestions	and si	upplied
Date of Examination			Signature of Medical Examiner					
Place of Examination			Stamp of					
Examiner's designation / qualification			Medical Examiner					
Examiner's license number or certification								

CTrustGlobal.com