



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 or ID card).

Full Name	
Address	
Email Address	Sex
Weight	Height
Marital Status	Occupation
Social Security No./National Id No./Passport Number	
Date and Place of Issue of Social Security No./National Id No./Passport Number	

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 dated 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 hospitalized? 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"/> |
| (b) Leprosy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Hepatitis (specify type) | 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"/> |
| (e) AIDS or AIDS related conditions, any Immune Deficiency Syndrome | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Genetic or Familial Disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Deafness or Chronic Ear Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Blindness or Eye Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (i) Any cancerous disease: benign/malignant | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (j) Headache migraine, epilepsy or dizziness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (k) Nervous or mental illness or disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (l) Any allergies, asthma or pulmonary disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (m) Cardiovascular diseases, arterial Hypertension | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (n) Liver, stomach or intestinal diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (o) Diabetes or other hormone diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Medical Examination

The Medical Examiner is required to examine the applicant and to answer the following questions. Give details and dates if any of the questions below are answered with "Yes".

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. **Urogenital Organs** – Any signs of abnormalities? Yes No

Urinalysis: Protein _____ Sugar _____ Sediment _____

10. **Nervous System and Sense Organs** – Any signs of abnormalities? Yes No

11. **Musculoskeletal System** – Any signs of abnormalities? Yes No

12. **Endocrine System** – Any signs of abnormalities, including thyroid? Yes No

13. **Various** – Any other signs of abnormalities? Yes No

14. **Final Evaluation**

15. **Comments**

Important: Please attach original results of the following

- (i) HIV test for all applicants over 5 years old
- (ii) Routine Blood and urine test
- (iii) Immunization schedule against the following
 - Diphtheria
 - Tetanus
 - Hepatitis
 - Influenza
 - Pneumococcus

Medical Examiner's Details and Declaration

Full Name and Qualifications	
Specialty	
Address	
Telephone No.	Email Address:
Fax No.	

I hereby confirm that I have identified, questioned and examined the applicant and have answered all questions to the best of my knowledge and in good faith.

Signature of Medical Examiner

Place and Date of Examination

Name and Stamp of Medical Examiner