A08:004

DEPARTMENT OF IMMIGRATION

MEDICAL FORM

PHOTOGRAPH

Name.....
(Surname – Block Letters) *(Other Names)*

Address.....

Citizen of.....

Passport No..... Date and Place of issue.....

Marital status.....

Names of children with dates of birth .....
.....
.....
.....
.....

Present Occupation.....

Intended Occupation in Barbados ..... No. of persons accompanying head of family .....

Have you ever been disabled or received compensation for injury? *If yes, state nature and date of disability or injury.* Yes ☐ No ☐

.....

Have you ever been hospitalised? *If yes, give name and address of hospital and date.* Yes ☐ No ☐

.....

Have you suffered from Tuberculosis or received treatment in a sanitorium? Yes ☐ No ☐

Have you suffered from:

	Yes	No		Yes	No
1. Nose bleeding	☐	☐	12. Palpitation	☐	☐
2. Coughing up blood	☐	☐	13. Shortness of breath	☐	☐
3. Bronchitis	☐	☐	14. Painful joints	☐	☐
4. Peptic Ulcer	☐	☐	15. Injuries	☐	☐
5 Jaundice	☐	☐	16. Operations	☐	☐
6. Gall Stones	☐	☐	17. Skin disorders	☐	☐
7. Diarrhoea	☐	☐	18. Fainting spells	☐	☐
8. Melaena	☐	☐	19. Fits, epilepsy	☐	☐
9. Haemorrhoids	☐	☐	20. Anaemia	☐	☐
10. Intestinal parasites	☐	☐	21. Haemoptysis	☐	☐
11. Rheumatic fever	☐	☐	22. Cancer, tumour or other growth	☐	☐

Physician's Signature..... *Signature*..... *Date*.....
(Applicant's)

Height.....ft.....ins.....cm.

Weight ..... lb ..... kg .....

Acuity of Vision

Hearing (Conversational Voice)

Rt. eye .....

Rt. ear.....ft.....cm.

Left eye .....

Left ear.....ft.....cm.

Throat.....

Nose.....

Neck.....

Lungs.....

Pulse Rate.....

Abdomen.....

Heart.....

External Genitalia .....

Blood Pressure..... *(Repeat if) (Abnormal)*

Rectum.....

Rt. Upper Limb.....

Left Lower Limb.....

Left Upper Limb.....

Right Lower Limb.....

Scars.....

Lymph Nodes.....

Operation Scars .....

C.N.S .....

Mental Development .....

Psychiatric Abnormalities .....

Urinalysis - Col. ..... Sp.g..... Alb..... Sug.....

VDRL/RCPF.....

Stool (microspic) *(If indicated)* .....

*Chest X-Ray .....

*Reports only accepted from: Consultant, Department of Radiology, Queen Elizabeth Hospital or Adviser on Chest diseases

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Conclusion .....

Prognosis .....

Date .....

.....

(Signature of Examining Doctor)

Name.....

(Please print)

Address.....

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Is Applicant medically fit for immigration? .....

.....

Date

.....

Medical Referee