

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 sanatorium? Yes No

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

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 (microscopic) *(If indicated)*

*Chest X-Ray

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

Conclusion

Prognosis

Date

(Signature of Examining Doctor)

Name.....
(Please print)

Address.....

Is Applicant medically fit for immigration?

Date

Medical Referee