TONGAN IMMIGRATION MEDICAL FORM

(Issued by the Ministry of Foreign Affairs)

Part A – Applicant's details

To be completed by the applicant before attending the medical examination. Please use a pen and write nearly in English using *BLOCK LETTERS*

For photograph

1. Your full name:

   Family name

   Given names

2. Your residential address:

3. Date of birth:

4. Sex: Male ☐ Female ☐

5. Country of citizenship

6. Marital status: Married ☐ Single ☐ Separated ☐

   Divorced ☐ Widowed ☐

7. Number of children born to applicant: ☐

1. Present occupation:

2. Medical History – Have you ever had:

		No	Yes
(a)	an operation?	☐	☐
(b)	hospital treatment or been admitted for any reason?	☐	☐
(c)	tuberculosis or have you ever coughed up blood?	☐	☐
(d)	convulsion, fits or epilepsy?	☐	☐
(e)	anxiety, depression or nervous complaints?	☐	☐

		No	Yes
(f)	high blood pressure, heart trouble, breathlessness and/or Chest pain?	☐	☐
(g)	pain in the back, neck or any joint?	☐	☐
(h)	stomach pains, indigestion or heart burn?	☐	☐
(i)	an infectious disease lasting more than 2 weeks?	☐	☐
(j)	kidney or bladder disease?	☐	☐
(k)	diabetes?	☐	☐
(l)	any illness, injury or medical condition lasting more than 2 weeks, or a recurring condition not mentioned above?	☐	☐
(m)	any medical, physical, psychological or other treatment in the last 5 years?	☐	☐

If you answered "Yes" to any of the above questions, you must provide all the relevant details, including dates.

_____

_____

_____

_____

3. Personal habits of applicant:		No	Yes
(a)	have you ever been addicted to a drug or taken drugs illegally?	☐	☐
(b)	do you consume alcohol?	☐	☐
	(If "yes" In what form _____		
	In what quantity (per week) _____		
(c)	do you smoke or have you ever smoked tobacco?	☐	☐
	(If "Yes" In what form _____		
	In what quantity (per day) _____		
(d)	do you have any physical or mental disabilities which may affect your ability to earn a living or take full care of yourself?	☐	☐

If you answered "Yes" to any of the above questions, you must provide all the relevant details, including dates.

_____

_____

_____

_____

Part B – Applicant's declaration

(To be signed and dated by the applicant in the presence of the examining doctor. A parent or guardian should sign on behalf of a child under 12 yrs of age)

4. ***"I declare that the information I have provided on this form is correct"***

Applicant's Signature ☐

Date: ☐ / ☐ / ☐
day month year

Part C – Examining doctor's findings

1. Height(cm) ☐ Weight (kg) ☐

2. Cardiovascular system:

Normal ☐ Abnormal ☐ → give details

3. Blood pressure (required for all persons 15 years or over)

Systolic _____ mmHg

Diastolic _____ mmHg

4. Respiratory System:

Normal ☐ Abnormal ☐ → give details

5. Nervous system/mental state/intelligence:

Normal ☐ Abnormal ☐ → give details

6. Gastro-intestinal system including hernial orifices:

Normal ☐ Abnormal ☐ → give details

7. Locomotor system/physical build (for all persons over 60, information on mobility must be included)

Normal ☐ Abnormal ☐ → give details

7. Skin and lymph nodes:

Normal ☐ Abnormal ☐ → give details

_____

_____

8. Urogenital system (including evidence of sexually transmitted disease)

Normal ☐ Abnormal ☐ → give details

_____

_____

9. Endocrine system:

Normal ☐ Abnormal ☐ → give details

_____

_____

10. Ear/nose/throat/teeth:

Normal ☐ Abnormal ☐ → give details

_____

_____

11. Hearing:

Right: Normal ☐ Abnormal ☐ → give details

Left: Normal ☐ Abnormal ☐ → give details

_____

_____

12. Eyes:

Normal ☐ Abnormal ☐ → give details

_____

_____

Visual acuity:

Uncorrected - Right ____/____ Left ____/____

Corrected - Right ____/____ Left ____/____

13. Are there any physical or mental conditions which may affect this persons ability to earn a living, take care of themselves or adapt to a new environment now or in future adult life?

No ☐ Yes ☐ → give details

_____

_____

14. Is this person pregnant?

No ☐ Yes ☐ → (Date of last monthly period: ____/____/____)
day month year

15. Dates of last Immunisation:

(required for children under 12 years)

* BCG	(/ /)	* Hepatitis B	(/ /)
* Diphtheria	(/ /)	* Tetanus	(/ /)
* Whooping cought	(/ /)	* Polio	(/ /)
	day month year		day month year

16. Urinalysis: (required for applicant 12 years or over)

Sugar ☐ Protein ☐

17. Blood Tests: *(required for each applicant 12 years of age or over)*

0 Human Immunodeficiency Virus (HIV)

Detected ☐ Not detected ☐

0 Hepatitis B antigen

Detected ☐ Not Detected ☐

0 Syphilis (RPR)

Reactive ☐ Non reactive ☐

18. Recommendation:

A (no significant history or abnormal finding present) ☐

B (significant history or abnormal findings present) ☐ → give details

_____

_____

19. Declaration:
(This declaration must be signed and dated by the doctor who personally performed the examination)

Full name (please print) ☐

Position ☐

Place of examination ☐

Telephone number ☐

"I declare that I have examined the applicant and that this is a true and correct record of my finding"

Examining doctor's signature ☐ Date / /
day month year

Part D – Applicant's Chest X-Ray Certificate

* *Chest X-Ray is required for each person 12 yrs of age or over*

* *Women who are pregnant are not required to undergo an X-Ray examination*

1. Is there any evidence of pulmonary tuberculosis (past or present)

   No ☐ Yes ☐

   If yes, please give details:

   _____

   _____

   _____

2. Is there any evidence of any other abnormality?

   No ☐ Yes ☐

   If yes, please give details:

   _____

   _____

   _____

3. Examining Radiologist Declaration:

   "The statements made by me in answer to all questions are true to the best of my knowledge and belief"

	/ /
Signature of Examining Radiologist	Day Month Year

Contact details:

Name: _____

Position: _____

Address: _____

Telephone: _____