



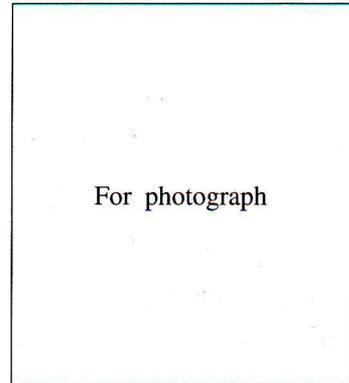
# TONGAN IMMIGRATION MEDICAL FORM

(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*



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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) pain in the back, neck or any joint?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) stomach pains, indigestion or heart burn?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) an infectious disease lasting more than 2 weeks?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) kidney or bladder disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) diabetes?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) any illness, injury or medical condition lasting more than 2 weeks, or a recurring condition not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) any medical, physical, psychological or other treatment in the last 5 years?                                      | <input type="checkbox"/> | <input type="checkbox"/> |

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

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- | 3. Personal habits of applicant:  | No                       | Yes                      |
|---|--------------------------|--------------------------|
| (a) have you ever been addicted to a drug or taken drugs illegally?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) do you consume alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (If "yes" In what form _____<br>In what quantity (per week) _____   |                          |                          |
| (c) do you smoke or have you ever smoked tobacco?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (If "Yes" In what form _____<br>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? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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**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

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

Systolic \_\_\_\_\_ mmHg

Diastolic \_\_\_\_\_ mmHg

3. Respiratory System:

Normal       Abnormal  → give details

4. Nervous system/mental state/intelligence:

Normal       Abnormal  → give details

5. Gastro-intestinal system including hernial orifices:

Normal       Abnormal  → give details

6. 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

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

Normal  Abnormal  → give details

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9. Endocrine system:

Normal  Abnormal  → give details

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10. Ear/nose/throat/teeth:

Normal  Abnormal  → give details

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11. Hearing:

Right: Normal  Abnormal  → give details  
Left: Normal  Abnormal  → give details

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12. Eyes:

Normal  Abnormal  → give details

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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

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14. Is this person pregnant?

No  Yes  → (Date of last monthly period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_)  
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:

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2. Is there any evidence of any other abnormality?

No  Yes

If yes, please give details:

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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: