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 neatly 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:
   (a) an operation? [ ] Yes [ ] No
   (b) hospital treatment or been admitted for any reason? [ ] Yes [ ] No
   (c) tuberculosis or have you ever coughed up blood? [ ] Yes [ ] No
   (d) convulsion, fits or epilepsy? [ ] Yes [ ] No
   (e) anxiety, depression or nervous complaints? [ ] Yes [ ] No
(f) high blood pressure, heart trouble, breathlessness and/or Chest pain?  

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<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
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(g) pain in the back, neck or any joint?  

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<th>No</th>
<th>Yes</th>
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(h) stomach pains, indigestion or heart burn?  

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<th>No</th>
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(i) an infectious disease lasting more than 2 weeks?  

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<th>No</th>
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(j) kidney or bladder disease?  

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<th>No</th>
<th>Yes</th>
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(k) diabetes?  

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<th>No</th>
<th>Yes</th>
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(l) any illness, injury or medical condition lasting more than 2 weeks, or a recurring condition not mentioned above?  

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<th>No</th>
<th>Yes</th>
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(m) any medical, physical, psychological or other treatment in the last 5 years?  

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<th>No</th>
<th>Yes</th>
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If you answered “Yes” to any of the above questions, you must provide all the relevant details, including dates.

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<tr>
<th>Date</th>
<th>Details</th>
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3. Personal habits of applicant:  

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<th>No</th>
<th>Yes</th>
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(a) have you ever been addicted to a drug or taken drugs illegally?  

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<th>No</th>
<th>Yes</th>
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(b) do you consume alcohol?  

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(If “yes” In what form  

In what quantity (per week)  

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(c) do you smoke or have you ever smoked tobacco?  

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(If “Yes” In what form  

In what quantity (per day)  

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(d) do you have any physical or mental disabilities which may affect your ability to earn a living or take full care of yourself?  

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<th>No</th>
<th>Yes</th>
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If you answered “Yes” to any of the above questions, you must provide all the relevant details, including dates.

<table>
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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

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

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
    Right: Normal □ Abnormal □ → give details
    Left: 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 person's 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: ___/___/___)
15. Dates of last Immunisation:
(required for children under 12 years)
- BCG (____/____/____)
- Hepatitis B (____/____/____)
- Diphtheria (____/____/____)
- Tetanus (____/____/____)
- Whooping cough (____/____/____)
- Polio (____/____/____)

16. Urinalysis: (required for applicant 12 years or over)
Sugar [ ] Protein [ ]

17. Blood Tests: (required for each applicant 12 years of age or over)
- Human Immunodeficiency Virus (HIV)
  Detected [ ] Not detected [ ]
- Hepatitis B antigen
  Detected [ ] Not Detected [ ]
- 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: ______________________