BELIZE

NATIONALITY & PASSPORT DEPARTMENT

PRELIMINARY MEDICAL EXAMINATION

EXAMEN MÉDICO PRELIMINAR

HOSPITAL / MEDICAL CENTER HOSPITAL/CENTRO MÉDICO ____________

A APPLICANT INFORMATION / *INFORMACIÓN DEL SOLICITANTE*

A01 LAST NAME(S) *APELLIDO(S)* ____________

A02 FIRST NAME(S) *NOMBRE(S)* ____________

A03 DATE OF BIRTH *FECHA DE NACIMIENTO* DAY / DÍA | MONTH / MES | YEAR / AÑO

A04 NATIONALITY *NACIONALIDAD* ____________

A05 PASSPORT NUMBER *NUMERO DE PASAPORTE* ____________

A06 GENDER *GÉNERO* ☐ MALE *MASCULINO* ☐ FEMALE *FEMENINO*

A07 MARITAL STATUS *ESTADO MARITAL* ☐ SINGLE *SOLTERO(A)* ☐ MARRIED *CASADO(A)* ☐ DIVORCED *DIVORCIADO(A)* ☐ WIDOWED *VIUDO(A)* ☐ COMMON-LAW *CONSENSUAL*

B QUESTIONS TO BE ANSWERED BY APPLICANT / *PREGUNTAS QUE DEBE RESPONDER EL SOLICITANTE*

B01 HAVE YOU BEEN EXAMINED FOR MIGRATION TO BELIZE? *¿HA SIDO EXAMINADO PARA INMIGRACIÓN A BELICE?* ☐ YES *SÍ* ☐ NO *NO*

B02 HAVE YOU EVER BEEN TREATED IN A HOSPITAL? *¿HA INGRESADO USTED ALGUNA VEZ A UN HOSPITAL?* ☐ YES *SÍ* ☐ NO *NO* **IF YES, SPECIFY BELOW /** *SI RESPONDE SI, ESPECIFIQUE ABAJO*

LIST OF NAMES OF HOSPITAL *LISTA DE NOMBRES DE HOSPITALES*	CONDITIONED TREATED *CONDICIÓN TRATADA*

B03 HAVE YOU EVER SUFFERED FROM OR RECEIVED TREATMENTS FOR PLEURISY OR TUBERCULOSIS OF ANY KIND, OR ATTENDED A SANATORIUM, OR TUBERCULOSIS CLINIC, EITHER AS A IN-PATIENT OR AS AN OUT-PATIENT? *¿HA SUFRIDO USTED ALGUNA VEZ O HA RECIBIDO TRATAMIENTO PARA PLEURESÍA O TUBERCULOSIS DE CUALQUIER TIPO, O ASISTIDO A UN SANATORIO, O CLÍNICA DE TUBERCULOSIS, YA SEA COMO PACIENTE INTERNO O EXTERNO?* ☐ YES *SÍ* ☐ NO *NO*

B04 HAVE YOU EVER BEEN A PATIENT IN A MENTAL INSTITUTION? *¿HA INGRESADO USTED ALGUNA VEZ COMO PACIENTE A UNA INSTITUCIÓN MENTAL?* ☐ YES *SÍ* ☐ NO *NO*

B05 ARE YOU RECEIVING, OR HAVE YOU EVER RECEIVED A DISABILITY PENSION? *¿ESTÁ USTED RECIBIENDO, O HA RECIBIDO ALGUNA VEZ UNA PENSIÓN POR INCAPACIDAD?* ☐ YES *SÍ* ☐ NO *NO*

C QUESTIONS TO BE ANSWERED BY MEDICAL PHYSICIAN / *PREGUNTAS QUE DEBE RESPONDER EL MÉDICO*

CHECK YES OR NO

Condition			Condition		
1. EYE TROUBLE OR TRACHOMA	☐ YES	☐ NO	12. STOMACH TROUBLE	☐ YES	☐ NO
2. NOSE OR THROAT TROUBLES	☐ YES	☐ NO	13. RHEUMATISM OR JOINT TROUBLE	☐ YES	☐ NO
3. EAR TROUBLE OR DEAFNESS	☐ YES	☐ NO	14. LUNGS DISEASE OR CHRONIC	☐ YES	☐ NO
4. HEAD INJURIES	☐ YES	☐ NO	15. HAY FEVER OR ASTHMA	☐ YES	☐ NO
5. BROKEN BONES	☐ YES	☐ NO	16. RHEUMATIC FEVER	☐ YES	☐ NO
6. BACK INJURIES	☐ YES	☐ NO	17. HEART DISEASE	☐ YES	☐ NO
7. HAEMORROHOIDS	☐ YES	☐ NO	18. FAINTING SPELLS	☐ YES	☐ NO
8. RUPTURE	☐ YES	☐ NO	19. FITS OR SIEZURE	☐ YES	☐ NO
9. KIDNEY OR BLADDER TROUBLES	☐ YES	☐ NO	20. NERVOUS DISORDER	☐ YES	☐ NO
10. VENERAL DISEASE	☐ YES	☐ NO	21. TROPICAL DISEASE	☐ YES	☐ NO
11. VARICOUSE VEINS	☐ YES	☐ NO	22. OPERATION/SURGERY	☐ YES	☐ NO

REMARKS ON POSITIVE FINDINGS ____________

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HEIGHT:	WEIGHT:	TEMP:	PULSE:
RESPIRATION:		PHYSIQUE:	
VISION: (WITHOUT GLASSES) RIGHT EYE 20/		LEFT EYE 20/	
EARS (DRUM):		RIGHT:	LEFT:
MOUTH:		THROAT:	
NOSE:		SPINE:	
HEART:			
BLOOD PRESSURE:		SYSTOLIC:	
DIASTOLIC:			
ABDOMEN:			
HERNIA:			
GENITO - URINARY:		PREGNANT:	
RECTUM:			
UPPER EXTREMITIES:		LOWER EXTREMITIES:	
SKIN:		LYMPHATIC SYSTEM:	
MENTAL DEVELOPMENT:		DULL:	NORMAL:
BELOW NORMAL:		PSYCHIATRIC ABNORMALITIES:	

BLOOD WASSERMAN IF INDICATED ______ STOOL EXAM ______ IF INDICATED ______

URINALYSIS IF INDICAED ______ (A) ALBUMEN ______ (B) SUGAR ______

(C) MICROSCOPIC ______

REMARKS ______

______

DIAGNOSIS ______

______

PROGNOSIS ______

______

ATTACHED ARE TEST RESULTS FOR :
1. HIV ☐ YES ☐ NO
2. VDRL ☐ YES ☐ NO
3. TB ☐ YES ☐ NO
4. OTHER ______ ☐ YES ☐ NO

DAY / DÍA | MONTH / MES | YEAR / AÑO

DATE

______
SIGNATURE OF APPLICANT
[MOTHER / FATHER]

______
SIGNATURE OF EXAMINING PHYSICIAN

LICENSE NO.: ______