# IMMIGRATION PHYSICALS

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WELCOME TO YOUR IMMIGRATION MEDICAL HISTORY AND PHYSICAL EXAM. TO PREPARE, PLEASE FILL OUT THE MEDICAL HISTORY FORM, AND BRING IT WITH YOU TO THE APPOINTMENT. MAKE CERTAIN THAT ALL THE INFORMATION BELOW IS PROVIDED OR COMPLETED. THE APPOINTMENT CAN TAKE UP TO 2 HOURS. BRING AN INTERPRETER IF NEEDED!

BRING THE FOLLOWING INFORMATION TO YOUR EXAM:

- FORM I-693, WITH YOUR PORTION COMPLETED, TYPED, OR PRINTED IN BLACK
- A GOVERNMENT ISSUED PHOTO ID (PASSPORT OR DRIVER'S LICENSE)
- MEDICAL RECORDS
- PRIOR CHEST X-RAY FILMS OR RESULTS
- IMMUNIZATION RECORD TRANSLATED INTO ENGLISH
- LIST OF HOSPITALIZATIONS AND DIAGNOSES
- INSTITUTIONALIZATIONS (PHYSICAL OR MENTAL)
- LIST OF DISABILITIES
- LIST OF MAJOR ILLNESSES (CURRENT OR PAST)
- PRIOR TUBERCULOSIS TREATMENT RECORDS IF ANY
- LIST OF PSYCHIATRIC ILLNESSES
- ALCOHOL USE HISTORY
- DRUG USE / ABUSE HISTORY
- HISTORY OF HARMFUL BEHAVIOR TO SELF OR OTHERS
- DOCUMENTS OF TREATMENT FOR TUBERCULOSIS – IF EVER (+)
- SCHOOL RECORDS IF AVAILABLE (DIPLOMAS, CERTIFICATES)
- EMPLOYMENT HISTORY

THE COST OF THE PROCESS IS $200. ALL ADDITIONAL REQUIRED SERVICES (X-RAYS, VACCINES, Tb TESTING…) ARE ADDITIONAL COST.

WE ACCEPT CASH, VISA AND MASTER CARD ONLY.

DR. JOSEPH WOLYNIAK

Name:___________________________________ Date of Birth:______________________________

Have you ever smoked cigarettes? YES NO

Do you currently smoke? YES NO

How many packs per day? _________________ For how long? ___________________ At what age started? ___________________

Do you currently drink alcohol? YES NO

How many beverages do you drink per week? ______________________________________________________________________

What type of alcoholic beverages do you drink? ____________________________________________________________________

**Check if you have any of the following symptoms currently:**

| **General** | | **GI** | | **Endocrine** | |
|---|---|---|---|---|---|
| Fever | | Problems Swallowing | | Excessive Thirst | |
| Swollen Glands | | Frequent Heartburn | | Always too Cold | |
| Weight Loss | | Diarrhea | | Always too Warm | |
| **Nose and Throat** | | Constipation | | **GU(Men Only)** | |
| Recurrent Nose Bleeds | | Change in Bowel Habits | | Lump in Testicle | |
| Ear Pain | | Bloody Stools | | Sore on Penis | |
| Eye Pain | | Black Tarry Stools | | Discharge From Penis | |
| Sores In Mouth | | Kidney/Bladder | | **GU (Women Only)** | |
| Persistent Hoarseness | | Blood in Urine | | Lump in Breast | |
| **Skin** | | Decrease in Force of Urination | | Nipple Discharge | |
| Rash | | Painful Urination | | Vaginal Discharge | |
| Change Moles | | Frequency in Urination | | Abnormal Vaginal Bleeding | |
| **Cardiopulmonary** | | **Neurological** | | **Other Allergies** | |
| Irregular Heartbeat | | Fainting Spells | | Bee Stings | |
| Shortness of Breath w/ Exertion | | Dizziness | | Eggs | |
| Shortness of Breath-Lying Flat | | **Musculoskeletal** | | Environmental | |
| Chest Pain | | Painful Joints | | Seasonal | |
| Chronic Cough | | Swollen Joints | | Others: | |
| Wheezing | | Painful Muscles | | | |
| Swollen Ankles | | Muscle Weakness | | | |
| Leg Cramps | | | | | |

**Are you in a high risk group for AIDS (i.e. homosexual, IV drug user, hemophiliac, etc.)? YES NO**

**Have you traveled internationally in the past? YES NO**

**If so, where?** ________________________________________________________________________________________

Name:_______________________________________ Date of Birth:_____________________________

**MEDICAL HISTORY AND REVIEW OF SYSTEMS:**

**Check box if you have ever had of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Asthma | | Emphysema | | Kidney Stones | |
| Angina | | Epilepsy | | Pancreatitis | |
| Anemia | | Gall Stones | | Poor Blood Clotting | |
| Arthritis | | Glaucoma | | Positive TB Test | |
| Blood Transfusions | | Fractures | | Rheumatic Fever | |
| Cancer | | Heart Failure | | Seizures | |
| Chronic Bronchitis | | Heart Murmur | | Stroke | |
| Cirrhosis | | Heart Attack | | Thrombophlebitis | |
| Colitis | | High Blood Pressure | | Tuberculosis | |
| Diabetes | | Hepatitis | | Thyroid Disease | |
| Diverticulosis | | Kidney Infection | | Ulcers | |
| Other | | | | Pregnancy | |

| **Operations:** | | **Allergies** |
|---|---|---|
| List any surgical operations you have had: | Date: | List any drugs you are allergic too |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |

| Medicines | | Immunizations/Vaccines |
|---|---|---|
| List all current medications | | Have you had the following? |
| 1. | | Tetanus |
| 2. | | Diptheria |
| 3. | | Influenza |
| 4. | | Pneumococcal |
| 5. | | Rubella |
| 6. | | Other: |
| 7. | | If female, do you take<br>Birth control? YES NO |
| 8. | | |

**Family Medical History**

| | | | | | |
|---|---|---|---|---|---|
| | Arthritis | | Kidney Disease | | Heart Attack |
| | Bleeding Tendency | | Liver Disease | | High Blood Pressure |
| | Cancer | | Obesity | | Stroke |
| | Diabetes | | Migraine Headaches | | Tuberculosis |

Name:_____________________________________________ Date of Birth:_______________________________________

## SUBSTANCE ABUSE HISTORY:

Have you ever or do you currently use: (check the appropriate circle)

- o Amphetamines
- o Anxiety medication
- o Barbiturates
- o Antidepressants
- o Cocaine
- o Heroin
- o Morphine
- o LSD / acid
- o Marijuana / hashish
- o Methamphetamines
- o Pain medication ( narcotic)
- o Other substance use / abuse

Describe the use (how often, when last used, treatments, hospitalizations):

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

## MENTAL HEALTH HISTORY:

Have you ever or do you currently have the following mental health concerns: (check the circle)

- o Anxiety
- o Panic
- o Depression
- o Suicide thoughts
- o Suicide plan
- o Attempted suicide
- o Self injury
- o Injured others
- o Post traumatic syndrome
- o Schizophrenia
- o Bipolar disorder
- o Other psychiatric / mental health concerns

Describe the mental health concern, prior therapy, treatments and hospitalizations, and current status:

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

# IMMIGRATION HISTORY QUESTIONAIRE

NAME: ______________________________________________ DATE OF BIRTH:____/____/____

PLACE OF BIRTH (COUNTRY):____________________CITIZENSHIP:_________________________

DATE OF ARRIVAL TO USA:____/____/____ FROM WHICH COUNTRY?:___________________

TRAVEL OUTSIDE OF USA SINCE ARRIVAL DATE? YES NO

LAST TRAVEL OUTSIDE OF THE USA:____/____/____ TO WHERE?_________________________

AND FOR HOW LONG? ________________________

HIGHEST GRADE ACHIEVED:______________________ DEGREE:_____________ TYPE:_________

NAME OF COLLEGE / UNIVERSITY ATTENDED:____________________________ DEGREE:_______

EMPLOYED IN THE USA CURRENTLY?_____ NAME OF COMPANY:__________________________

PRESENT OCCUPATION: STUDENT EMPLOYED UNEMPLOYED RETIRED OTHER:____________

MARITAL STATUS: S M W D OTHER:_____________________________________________

NUMBER OF CHILDREN:____________________ AGES OF CHILDREN:______________________

Name: ________________________________________ Date of Birth:___________________________________

# Tuberculosis Questionnaire

**Have you had any of the following symptoms in the past 1 year?**

- Productive cough for over 3 weeks YES NO
- Coughing up blood YES NO
- Fever, chills or night sweats for an unknown reason YES NO
- Unexplained weight loss YES NO
- Chest Pain YES NO

- Have you ever has the BCG vaccine? YES NO
- Have been in close contact with anyone with active Tb in the last year? YES NO
- Do you have any immune system problems? YES NO
- Have you ever had an organ transplant? YES NO
- Have you taken steroids for any reason in the last 2 months? YES NO
- Have you ever had a positive Tuberculosis test? YES NO
- Have you ever had an IGRA (Interferon Gamma Release Assay) test? YES NO
- Have you ever been treated for Tuberculosis? YES NO
- Have you ever had a chest x-ray for a positive Tb Test? YES NO
- Have you ever had a severe reaction to Tuberculosis testing? YES NO
- Have you had intestinal bypass surgery? YES NO