IMMIGRATION MASTER FORM (patient)

LAST NAME_____FIRST NAME_____

COUNTRY OF BIRTH _____DATE OF BIRTH_____

CITY OF BIRTH _____PASSPORT #_____

Please answer the following questions to the best of your ability. It will assist the physician in your evaluation. Please explain any "Yes" answers in the space at the bottom of this page.

1.	Do you have any medical illnesses or conditions?	Yes	No
2.	Do you have any mental or psychiatric illness?	Yes	No
3.	Do you take prescription medications?	Yes	No
4.	Are you allergic to any medication or foods?	Yes	No
5.	Have you ever been hospitalized?	Yes	No
6.	Have you undergone surgery?	Yes	No
7.	Do you use illegal drugs of any kind?	Yes	No
8.	Do you have a history of alcohol overuse or abuse?	Yes	No
9.	Are you currently in a drug or alcohol treatment program?	Yes	No
10.	Do you smoke cigarettes or use tobacco products?	Yes	No
11.	Do you have any serious or chronic injury-related conditions?	Yes	No
12.	Have you ever suffered from any sexually transmitted disease (STD)?	Yes	No
13.	Are you dependent on others to meet your daily personal care needs?	Yes	No
14.	Are you physically **NOT** able to attend school and/or work?	Yes	No
15.	Are your immunizations documented in a language other than English?	Yes	No
16.	To your knowledge, have you ever had varicella (chicken pox)?	Yes	No
17.	Have you ever been diagnosed with or treated for tuberculosis (TB)?	Yes	No
18.	Have you ever had a positive test for TB (blood or skin testing)?	Yes	No
19.	Women: Are you pregnant? If yes, your "due date": _____	Yes	No
	Are you attempting to become pregnant?	Yes	No
	Are you breast feeding?	Yes	No

I affirm that the above information is true to the best of my knowledge.

Examinee signature **Date**