WELCOME

222Route 299 Highland, NY 12528
845-691-DOCS (3627)

Immigration Physical I-693

Patient Account # _______________

PATIENT INFORMATION Date _________

Last Name _________________________________First Name_________________________ Middle Name ________________

Street name and number ____ Apt. # ____________

City, State, Zip Code ____

Home Phone # ____________________________________ Cell Phone #_______________________________________

SEX: ☐ M ☐ F Birth date__________________ Age______ ☐Single☐Married☐Partnered☐Widowed☐Separated☐Divorced

A-Number ____Patient SS#____________________________________

City/Town/Village of Birth _________________________________ Country of Birth _________________________________

Email Address (*for health newsletter & medical alerts)* ______________________________________

Please complete the reverse side of this form

Medical History

Patient Name: ___________________________

Do you have a history of any of the following? Please answer with "YES" or "NO"

Tuberculosis ___________________________ Granuloma Inguinale ____________________
Lymphogranuloma Venereum _____________ Hansen's Disease/Tuberculosis____________
Mental Illness/ Insanity __________________ Syphilis _______________________________
Mental Defect/Mental Retardation _________ Cancroids _____________________________
Drug or Alcohol Abuse ___________________ HIV or AIDS ___________________________
BCG (Tuberculosis) Vaccination ____________ Chicken Pox ____________________________

PAST MEDICAL HISTORY (Check all that apply for you)

☐Breast lump ☐Diabetes ☐Hepatitis ☐Kidney Disease ☐Pacemaker ☐Stroke
☐Appendicitis ☐Cancer - Type________________ ☐Epilepsy ☐Herpes ☐Liver Disease
☐Cataracts ☐Emphysema ☐High Cholesterol ☐Measles ☐Polio ☐Arthritis
☐Asthma ☐Glaucoma ☐High Blood Pressure ☐Migraine Headaches ☐Prostate Problems ☐Ulcers
☐Bleeding disorder ☐Heart Disease ☐Multiple Sclerosis ☐Rheumatic Fever ☐Venereal Disease
☐COPD ☐Mumps ☐Scarlet Fever ☐Thyroid Problems

Last Physical Exam________________________Past Surgeries ____

List any medications you are currently taking: ___________
____
____

List any allergies to medications or substances that you have:
____
____

Check which substances you use and how much you use them.

☐Caffeine________ ☐Drugs_______ ☐Tobacco_______
☐ Alcohol_________ ☐Other_______________________

Check if your work exposes you to any of the following:
☐Stress ☐Heavy lifting ☐ Hazardous Substances
☐Other ________________________________

FAMILY HISTORY

Father ☐ Alive ☐ Deceased Present Health or cause of death ________________________________
Mother ☐ Alive ☐ Deceased Present Health or cause of death ________________________________
Brothers No. Alive_____ Health ___________________No. Deceased_______ Cause of death _____________
Sisters No. Alive_____ Health ___________________No. Deceased_______Cause of death _____________
No. of Children______ Name(s) and age____
____
Have any of the above persons have or have had any of the following conditions: ☐Diabetes☐Cancer☐ Heart disease
☐Stroke ☐High blood pressure☐Nervous illness☐Bleeding tendency ☐Allergy☐kidney disease☐other______________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

*SIGNATURE*____DATE______________________________