

MEDICAL HISTORY AND PHYSICAL EXAMINATION MEDICAL WORKSHEET THREE

For use with Main Medical Form

Name (<i>Last, First, MI</i>)	Exam Date (<i>mm-dd-yyyy</i>)
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Birth Date (<i>mm-dd-yyyy</i>)	Passport Number	Alien (Case) Number
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1. Past Medical History (*indicate conditions requiring medication or other treatment after resettlement and give details in Remarks*)
 NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> General Illness or injury requiring hospitalization (<i>including psychiatric</i>)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiology Angina pectoris Hypertension (<i>high blood pressure</i>) Cardiac arrhythmia Congenital heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonology History of tobacco use Current use <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma Chronic obstructive pulmonary disease (<i>emphysema</i>) History of tuberculosis (<i>TB</i>) disease Treated <input type="checkbox"/> Yes <input type="checkbox"/> No Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurology and Psychiatry History of stroke, with current impairment Seizure disorder Major impairment in learning, intelligence, self care, memory, or communication Major mental disorder (<i>including major depression, bipolar disorder, schizophrenia, mental retardation</i>) Use of drugs other than those required for medical reasons Addiction or abuse of specific* substance (<i>drug</i>) *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics Other substance-related disorders (<i>including alcohol addiciton or abuse</i>) Ever taken action to end your life</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Obstetrics and Sexually Transmitted Diseases Pregnancy Fundal height _____ cm Last menstrual period Date (<i>mm-dd-yyyy</i>) _____ Sexually transmitted diseases, specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Endocrinology and Hematology Diabetes mellitus Thyroid disease History of malaria</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Malignancy, specify _____ Chronic renal disease Chronic hepatitis or other chronic liver disease Hansen's Disease <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Visible disabilities (<i>including loss of arms or legs</i>), specify _____ _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other requiring treatment, specify _____ _____ _____</p>
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2. Physical Examination (*indicate findings and give details in Remarks*)

No Yes Applicant appears to be providing unreliable or false information, specify _____

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____
 BP _____ / _____ (mmHg) Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*		N*	A*	ND*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (<i>including adenopathy</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (<i>including pulses, edema</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (<i>including gait</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (<i>include dental</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (<i>including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (<i>S1, S2, murmur, rub</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (<i>including nerve enlargement</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (<i>including mood, intelligence, perception, thought processes, and behavior during examination</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (<i>including liver, spleen</i>)				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (<i>including circumcision, infection(s)</i>)				

