

APPLICANT'S MEDICAL HISTORY & PHYSICAL EXAMINATION

Name: (Last, First, M)			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date (mm-dd-yyyy):	Passport Number:	Date of Issue (mm-dd-yyyy):	Alien (Case) Number:	
Birth Place (City / Country):			Height:	Weight:
Present Address:		Occupation:		Age:
Local Phone Number:			Email Address:	

Past Medical History (*indicate conditions requiring medication or other treatment after resettlement and give details in "Remarks"*)

NOTE: The following information is self-reported, has not been verified by a physician, and should not be medically definitive.

<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 20px;">NO</td> <td style="text-align: center; width: 20px;">YES</td> <td style="width: 10px;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Illness or injury requiring hospitalization <i>(including psychiatric)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Heart disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Hypertension</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>History of tobacco use Current use: ____ Yes ____ No</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Asthma</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Lung disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>History of stroke, with current impairment</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Seizure disorder (fits)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Major impairment in learning, self care, Intelligence, memory or communication</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Major mental disorder (<i>including major depression, bipolar disorder, mental retardation, schizophrenia</i>)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Current or past use of drugs (including ganja) not prescribed by a doctor</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Other substance related disorders <i>(including alcohol addiction or abuse)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 10px;"></td> <td>Have you ever taken action to end your life?</td> </tr> </table>	NO	YES			<input type="checkbox"/>	<input type="checkbox"/>		Illness or injury requiring hospitalization <i>(including psychiatric)</i>	<input type="checkbox"/>	<input type="checkbox"/>		Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		History of tobacco use Current use: ____ Yes ____ No	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Lung disease	<input type="checkbox"/>	<input type="checkbox"/>		History of stroke, with current impairment	<input type="checkbox"/>	<input type="checkbox"/>		Seizure disorder (fits)	<input type="checkbox"/>	<input type="checkbox"/>		Major impairment in learning, self care, Intelligence, memory or communication	<input type="checkbox"/>	<input type="checkbox"/>		Major mental disorder (<i>including major depression, bipolar disorder, mental retardation, schizophrenia</i>)	<input type="checkbox"/>	<input type="checkbox"/>		Current or past use of drugs (including ganja) not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>		Other substance related disorders <i>(including alcohol addiction or abuse)</i>	<input type="checkbox"/>	<input type="checkbox"/>		Have you ever taken action to end your life?	<table style="width: 100%; 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GIVE DETAILS BELOW OF ANY CONDITIONS MENTIONED ABOVE:

I certify that the above information is true and that I have not withheld any major information regarding any medical history. I understand that if at any time it is proved that medical information has been withheld, I may be refused a visa. I also certify that I understand the purpose of the medical examination, and I authorize the required tests below to be completed. The information on this form refers to me.

Signed: _____ (Applicant) _____ (Date)

DO NOT WRITE BELOW THIS LINE

HIV & VDRL <input type="checkbox"/>				X-Ray <input type="checkbox"/>		Medical Examination <input type="checkbox"/>	
Vision	Uncorrected	L 20/	R 20/	BP	Pulse	Resp.	
	Corrected	L 20/	R 20/				

Remarks: _____

IF WE CANNOT REACH YOU, WHO IN JAMAICA CAN WE CALL?

PERSON'S NAME.....

PERSON'S TELEPHONE NUMBER:.....

THEIR RELATIONSHIP TO YOU:.....

WHERE ARE YOU GOING TO LIVE IN AMERICA?

STREET ADDRESS:.....

CITY:.....

STATE:.....

ZIP CODE:.....

**FEMALES, PLEASE LIST ALL THE DATES YOU HAVE GIVEN BIRTH
(DAY/MONTH/YEAR)**

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