Instructions for Medical Examination for Immigration

Please call between 9 a.m. and 4 p.m. to schedule an appointment.

For Inova Urgent Care in Centreville, call **703-830-5600.**
For Inova Urgent Care in Vienna, call **703-938-5300.**

Please fill out all the forms you have downloaded from this web site. Bring these forms, along with the following, to your appointment:

- Any immunization / vaccine records you may have
- Passport-size photo to attach to your I-693 form
- Photo ID, i.e., driver's license or passport
- Form of payment for the exam (cash, credit card or personal check)

PLEASE COMPLETE THE FOLLOWING INFORMATION
(PLEASE PRINT CLEARLY AND LEGIBLY)

REASON FOR VISIT:_____

PATIENT INFORMATION:

PATIENT LAST NAME:_____FIRST:_____MI:_____

ADDRESS:_____APT #:_____

CITY:_____STATE:_____ZIP:_____

TELEPHONE CONTACT: HOME: (_____)_____ CELL: (_____)_____

SOCIAL SECURITY #:_____-____-_____ SEX: □ M □F DATE OF BIRTH:_____/_____/_____ AGE:____

EMERGENCY CONTACT:_____

LOCAL ADDRESS (IF DIFFERENT):_____

CITY:_____STATE:_____ZIP:_____

TELEPHONE CONTACT: HOME: (_____)_____ CELL: (_____)_____

IF PATIENT IS A MINOR:

PARENT / GUARDIAN NAME:_____RELATIONSHIP:_____

ADDRESS (IF DIFFERENT):_____

CITY:_____STATE:_____ZIP:_____

TELEPHONE CONTACT: HOME: (_____)_____ CELL: (_____)_____

IF YOU ARE COVERED BY AN INSURANCE PLAN, PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST.

(S)HE WILL ADVISE YOU IF WE ACCEPT YOUR INSURANCE AND MAKE A COPY OF YOUR CARD FOR OUR RECORDS.

NAME OF INSURANCE COMPANY: _____

SUBSCRIBER'S NAME:_____RELATIONSHIP TO PATIENT:_____

ID#/POLICY NUMBER:_____ GROUP # _____

DATE:_____

INOVA HEALTH SYSTEM

PHYSICAL FORM

Name: _____ Exam Date: _____

SSN#: _____

Date of Birth: _____

Sex: ❑ M ❑ F

MEDICAL HISTORY

YES	NO	*(Explain all "YES" answers in space below.)*
		1. Have you had or been advised to have any operations? If yes, give DATE AND REASON.
		2. Have you ever been in the hospital overnight for any other reason? If yes, give DATE AND REASON.
		3. Have you ever been a patient, committed or voluntary, in a mental hospital or sanitarium?
		4. Are you presently under the care of a physician for any current medical problems? Explain.
		5. Are you presently taking any medicines? List kind and dosage. Do you have any allergies?
		6. Do you smoke? List packs per day and number of years.
		7. Do you drink alcoholic beverages? Give amount and frequency.
		8. Do you use any other drugs? List kind and frequency.

NUMBER	If you answered "YES" to any of the questions above, please explain:

Do you have or have you ever had? *Please check each item. If "YES", give details where indicated on next page.*

	YES	NO			YES	NO	
1.			unusual skim lumps or moles	10.			tuberculosis
2.			jaundice (yellow skin)	11.			chronic cough or coughed up blood
3.			frequent or severe headaches	12.			pain or pressure in chest
4.			sinusitis	13.			abnormal electrocardiogram
5.			visual problems ❑ glasses ❑ contacts	14.			high blood pressure
6.			impaired hearing	15.			irregular or rapid heart beat
7.			ear, nose or throat problems	16.			heart disease or murmur
8.			asthma/wheezing	17.			stomach, liver, gall bladder, or intestinal problems
9.			shortness of breath	18.			rupture or hernia

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Do you have or have you ever had? *Please check each item. If "YES", give details where indicated below.*

	YES	NO			YES	NO	
19.			hemorrhoids or rectal disease	35.			diabetes (or sugar in urine)
20.			recurrent diarrhea or constipation	36.			anemia or other blood conditions
21.			frequent or painful urination	37.			loss of leg, finger, toe
22.			kidney stone or blood in urine	38.			loss of any body organ
23.			prostate trouble	39.			any recent gain or loss of weight
24.			dizziness or fainting spells	40.			tumor growth or cancer
25.			head injury or loss of consciousness	41.			sexually transmitted disease (active or current)
26.			stroke or paralysis	42.			loss of memory
27.			epilepsy, fits or seizures	43.			depression or excessive worry
28.			rheumatic fever	44.			nervous problems or anxiety
29.			swollen or painful joints	FEMALES ONLY			
30.			painful or trick shoulder, elbow or knee		YES	NO	
31.			foot trouble				Are you pregnant?
32.			back injury or strain				Date of last menstrual period
33.			fractures, broken bones				Date of last pap smear
34.			goiter or thyroid problems				Date of last mammogram

NUMBER	If you answered "YES" to any of the questions above, please explain:

I understand that this screening examination is <u>not</u> considered to be a substitute for a regular examination by my private physician.

Patient: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____

Physician: _____ Date: _____

INOVA HEALTH SYSTEM

TUBERCULIN SKIN TEST (TST) REPORT

☐ UCCP	☐ HEALTHPLEX OHC	☐ ALEXANDRIA OHC	☐ ECCF	☐ UCCD	☐ UCCC	☐ UCCV
540-338-4995	703-797-6844	703-504-6600	703-877-8200	703-722-2500	703-830-5600	703-938-5300
FAX 540-338-2483	FAX 703-797-6859	FAX 703-504-6607	FAX 703-934-5076	FAX 703-327-1850	FAX 703-830-6942	FAX 703-242-0726

Name: _____ Date: ____/____/____

S.S.N.: ____-____-____ Date of Birth ____/____/____ Sex: ☐ Male ☐ Female

Phone: ( ) ____ - _____ Employer: _____

Reason for Testing: ____Preplacement ____Annual ____Post Exposure ____Immigration

QUESTIONS

1. Have you ever had a **TB** skin test before? ____Yes ____No ____I do not know

   If yes, was it ever positive ____yes ____No ____I do not know

   If it was positive, how long ago and where did you receive this test: _____

   Did you receive any treatment or medication for TB? _____

Do you have any of the following:

a. Sensitivity / allergy to PPD serum?	____Yes	____No
b. Received polio vaccine in the last 4-6 weeks?	____Yes	____No
c. Received MMR in the last 4-6 weeks?	____Yes	____No
d. Received varicella vaccine in the last 4-6 weeks?	____Yes	____No
e. Receiving corticosteroid/other immunosuppressive therapy?	____Yes	____No

3. Have you ever received **BCG** vaccine? ____Yes ____No

   If yes, how long ago and where did you receive this inoculation: _____

*****You must return within 48-72 hours to have the test results read. *****

Return On: ____/____/____ **After:** ____:____ **OR** ____/____/____ **Before:** ____:____

I have read and understand that these are the only times in which this TB test will be accurately read.

Signature: _____ **Date:** ____/____/____

*****The patient named above has been tested for exposure to Tuberculosis using Purified Protein Derivative diluted to equal standard 5 Tuberculin Units, in the amount of 0.1cc intradermally. This is the standard Mantoux test.

Date of Placement: ____/____/____ Time of Placement: ____:____

Location of Placement: ☐ Right Forearm ☐ Left forearm ☐ Other Site_____

Lot #: _____ Exp. Date: ____/____/____ Manufacturer: _____

Placed By: _____ R.N. _____

Date of Reading: ____/____/____ Time of Reading: ____:____

RESULTS: ☐ Negative ____MM ☐ Positive ____MM

- ☐ This person has completed negative (0mm) testing.
- ☐ Incomplete testing, failed to return at specified time.
- ☐ Requires 2-step testing ☐ Yes ☐ No Return for #2 on ____/____/____
- ☐ Chest X-ray done ☐ Yes ☐ No Result: _____
- ☐ Referred to PMD or County Health Department for possible medication and/or treatment

Reading Completed by: _____ **R.N. / M.D.**

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