E L I T E M E D I C A L C L I N I C

P A T I E N T I N F O R M A T I O N
I M M I G R A T I O N P H Y S I C A L

DATE: _____

LEGAL PASSPORT NAME: _____
Last First Middle

ADDRESS:_____

City: _____ State: _____Zip: _____

CELL PHONE: _____ HOME PHONE: _____

E-MAIL: _____ AGE: _____

DATE OF BIRTH: _____-_____-_____SEX: Male / Female MARITAL STATUS: Married Single Other

CITY OF BIRTH: _____ COUNTRY OF BIRTH:_____

SOCIAL SECURITY #: _____-_____-_____ ALIEN #: _____

DRIVER'S LICENSE #: _____ PASSPORT #:_____

Immigration Attorney _____ Phone Number _____

Emergency Contact: _____ Phone: _____ Relation_____

Past Medical Illness(es): _____

Chronic Physical Illness(es): ❑ NO ❑ YES _____

Chronic Mental Illness(es): ❑ NO ❑ YES _____

Current Medication(s): ❑ NO ❑ YES _____

Do you have any allergies to medication? ❑ NO ❑ YES Please explain: _____

Do you have **any allergies to a vaccine** in the past? ❑ NO ❑ YES Please explain: _____

Do you have **any allergies to food** such as eggs? ❑ NO ❑ YES Please explain: _____

Do you have **any cough, night sweats, abnormal weight loss**? ❑ NO ❑ YES Please explain: _____

Do you have **psychiatric issues, homicidal thoughts, etc**? ❑ NO ❑YES Please explain: _____

Are you pregnant now or is there a possibility you are pregnant? ❑ NO ❑ YES

List all vaccines you have had and dates (Vaccination record required): _____

_____

The above information is accurate to my best recollection. I am responsible for all fees associated with the visit. Payment is due at the time of service.

Patient/Parent/Guardian Signature _____ Date _____