OSCAR MEDICAL CENTER IMMIGRATION REGISTRATION FORM

Date: ____________________________

Last Name_____________________________ First Name_______________________________ Middle _______

Address____ APT_________

City_________________________________ State_____________ Zip______________

Home phone#_________________________ Cell Phone #_________________________ Sex: M F

Date of Birth__________________ Email____

City and Country of birth_________________________ ________________________________

Please answer YES or NO

Question	Initial Here
If female, are you pregnant? YES NO NA	
Have you ever had Chicken Pox Disease or a Varicella Vaccine? YES NO	
Do you any symptoms that you think might be from an STD? YES NO	
Chancroid Y N Granuloma Y N Gonorrhea Y N Lymphogranula Y N	
Do you any physical or mental disorders with Associated Harmful Behavior YES NO	
Are you a problem drinker or an alcoholic? YES NO	
Have you ever used street drugs? YES NO	
Have you ever been diagnosed with Leprosy or Hansen's Disease? YES NO	
Have you traveled outside the United States within the last three months? YES NO	

Alien Registration # (A Number) (If any) ____________________________

DO NOT WRITE BELOW THIS LINE. FOR DOCTOR'S USE ONLY.

General Appearance____

Height ________________ Weight ________________ Blood Pressure __________________

Respirations___________________Temp___________Pulse______________ BMI _______________

Rhythm______________________________ EENT____

Glandular & Lymphatic System____

Respiratory System____

Cardiovascular System____

Abdomen____

Neurological____

Previous Surgery____

TB Test: Date Given: _____/_____/_____ TB Test: Date read: _____/_____/_____

TB Results___________________________ Lot #, Date of Exp: ______________________________

DOCTORS SIGNATURE: ____

DATE OF EXAM: ____