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USCIS MEDICAL HISTORY FORM

PLEASE COOPERATE WITH OUR EFFORTS TO BETTER SERVE YOU BY COMPLETING THIS FORM AS ACCURATELY AS POSSIBLE.

Name _____ : Date of Birth _____ Age _____

List any active medical problems for which you see a doctor on a regular basis;

Date of last physical exam with your primary doctor: _____

Please list all medications that you are on at this time.

Allergies: Please list all known and suspected allergies, especially to medicines:

Past Medical History: Please review and indicate any of the above conditions that apply to you:

	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any OTHER pertinent medical issues that you think are relevant

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

REVIEWED BY PECOS T. OLURIN MD _____