Division of Immigration Health Services History and Physical Examination Form

History of Present Illness

Currently have or ever had *(please circle):*

Athsma	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No			
Epilepsy	Yes	No	Malaria	Yes	No
Heart Trouble	Yes	No	Mental Illness	Yes	No
Hepatitis	Yes	No	Tuberculosis	Yes	No
+ HIV	Yes	No	Venereal Disease	Yes	No
			Other: _____		

Family History of *(please circle):*

Athsma	Yes	No	High Blood Pressure	Yes	No
Cancer	Yes	No			
Diabetes	Yes	No	Mental Illness	Yes	No
Epilepsy	Yes	No	Tuberculosis	Yes	No
Heart Trouble	Yes	No			
			Other: _____		

Ever Hospitalized? No____ Yes____, list: _____

Female: Pregnant? No____ Yes____, LMP _____ Gravida _____ Para _____

Current Health: Good____ Fair____ Poor____ Explain: _____

Any special health requirements? No____ Yes____, list: _____

Current Medication(s): _____

Known allergies to medication(s):_____No_____Yes, list: _____

Other Allergies:_____No_____Yes, specify: _____

Chemical Dependence? (alcohol, drugs) _____No_____ Yes, If Yes: Substance: _____ Date of last use:_____

Do you have any pain?_____No_____ Yes, If Yes: Where? _____ How often does it occur? _____

How long does it last? _____ What helps? _____ Describe the pain: _____

Comments: _____

General Appearance: _____

Temperature:_____ Pulse:_____ Blood Pressure:_____ Weight:_____

Height:_____Visual Acuity: Right 20/_____ Left 20/ _____

_____ _____

Provider's Signature *Date* *Printed Name of Provider*

IMPRINT OF DETAINEE ID PLATE, COMPUTER LABEL OR COMPLETE BELOW:	
1. Name: (Last) (First)	
2. DOB:	3. A #
4. Nationality:	5. Facility: