Occupational Medicine Services

☐ **Bethesda Care Arrow Springs**
Phone: 513-282-7075
Fax: 513-282-7076

☐ **Bethesda Care Butler County**
Phone: 513-874-3990
Fax: 513-860-5071

☐ **Bethesda Care Eastgate**
Phone: 513-752-3695
Fax: 513-752-3039

☐ **Bethesda Care Norwood**
Phone: 513-731-3399
Fax: 513-731-2882

☐ **Bethesda Care Queensgate**
Phone: 513-241-4135
Fax: 513-241-6510

☐ **Bethesda Care Sharonville**
Phone: 513-563-1505
Fax: 513-769-4776

☐ **Good Samaritan**
Phone: 513-862-2875
Fax: 513-862-2860

IMMIGRATION MEDICAL HISTORY/PHYSICAL EXAM

Name:	Sex M F	Date of Birth

Have you had or do you now have any of the following conditions? Check (✓) 'Yes' or 'No.' Indicate age when condition occurred.

	Yes	No	Age		Yes	No	Age		Yes	No	Age
Allergies, hay fever, drug reaction				Epilepsy or seizures				Other autoimmune disorder(s)			
Asthma				Eye trouble, injury, blindness				Paralysis			
Anemia or blood disease				Headaches, frequent or severe				Polio			
Back trouble				Hearing loss				Psychiatric Illness			
Bone or joint deformity				Heart trouble				Rectal disease, blood in stool, hemorrhoids			
Cancer or tumor				Hepatitis or liver disease				Rheumatism or arthritis			
Chest pain or pressure				High blood pressure				Sexually transmitted diseases (STD)			
Chronic cough				Kidney stone or blood in urine				Skin disease			
Compromised immune system				Mental Retardation				Thyroid trouble			
Depression				Memory loss				Tuberculosis			
Diabetes				Nervous breakdown				Ulcers			
Dizziness/fainting spells, head injury or loss of consciousness											

Yes	No	HISTORY
❐	❐	Have you ever been hospitalized? Date(s): Reason:
❐	❐	Have you ever had surgery? Date(s): Type of surgery:
❐	❐	Have you had any major illnesses in the past five (5) years? Date(s): Condition:
❐	❐	Are you currently being treated for a medical condition? Condition:
❐	❐	Are you currently taking any medications either prescribed or over the counter (include birth control pills or herbs)? List medication(s):
❐	❐	Do you currently have swelling, pain or open sores in the genital area?
❐	❐	Do you presently consume alcoholic beverages? Type: # Days per week: Amount per day:
❐	❐	Have you ever been diagnosed or treated for alcohol abuse or alcoholism?
❐	❐	Have you ever been charged with a crime (excluding a speeding or parking ticket)?
❐	❐	Do you now use or have you ever used illegal drugs or controlled substances without a medical prescription?
		How long have you lived in the United States? Number of Years:

Signature of Immigrant: ____ Date: ____________________

IMMIGRATION MEDICAL HISTORY/PHYSICAL EXAM

(to be completed by examiner)

Name: ______________________________ SSN: ____________________

BP: ________ Pulse: ________

Repeat BP: ________ Ht: __________ Wt: __________

Without glasses	Both: _____	Far Rt: _____	Far Lt: _____
With glasses or contacts	Both: _____	Far Rt: _____	Far Lt: _____
Color vision	☐ Normal	☐ Abnormal	
Test Type:	☐ Able to distinguish red/amber/green ☐ Ishihara ☐ Titmus		
Peripheral vision	Rt: __________	Lt: __________	

URINE MULTISTIX		
Test	**Normal Range**	**Results**
Glucose	*Negative*	
Bilirubin	*Negative*	
Ketone	*Negative*	
Specific Gravity	*1.001 - 1.030*	
Blood	*Negative*	
pH	*5-9*	
Protein	*Negative - Trace*	
Urobilinogen	*0.2 – 1.0 mg/dL*	
Nitrites	*Negative*	
Leukocytes	*Negative*	

	NORMAL	ABNORMAL	COMMENTS
General Appearance			
Skin			
HEENT			
Neck			
Lungs			
Heart			
Vascular			
Abdomen			
Inguinal/genitalia			
Extremities			
Spine Curvature			
Range of Motion			
Straight Leg Raising			
Gait			
Neurological			
Psychological			

☐ Normal

COMMENTS: ____

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Examiner Signature: ______________________________ Date: ____________________