



**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
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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
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hospitalized? Date(s): Reason:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery? Date(s): Type of surgery:
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any major illnesses in the past five (5) years? Date(s): Condition:
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently being treated for a medical condition? Condition:
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medications either prescribed or over the counter (include birth control pills or herbs)? List medication(s):
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently have swelling, pain or open sores in the genital area?
<input type="checkbox"/>	<input type="checkbox"/>	Do you presently consume alcoholic beverages? Type: _____ # Days per week: _____ Amount per day: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed or treated for alcohol abuse or alcoholism?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been charged with a crime (excluding a speeding or parking ticket)?
<input type="checkbox"/>	<input type="checkbox"/>	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: _____