NAVIGATION MEDICAL CENTER
Jaime E. Duarte MD FAAFP
Sonia P. Moncayo MD
3003 Navigation Blvd., Houston, TX 77003. Fax: 713-223-1571 Phone: 713-223-4466
www.navigationmedical.com

Patient's Name: _____ DOB: _____

Medical History Form (For Immigration Examination)

1. Have you had any change in your general health within the past year? ..... __Yes __No
2. Are you under the care of a Doctor? ..... __Yes __No
   If so, what is the condition being treated? _____
3. Have you had any serious illness, surgeries, or hospitalization? ..... __Yes __No
4. Are you taking medicines including non-prescription medicines? ..... __Yes __No
5. Do you have or have you had any of the following diseases or problems?
   Heart diseases (high blood pressure, heart murmur, congenital heart diseases) __Yes __No
   Lung problems (asthma, pneumonia, chronic cough, tuberculosis ..... __Yes __No
   Neurological problems, fainting spell or seizures ..... __Yes __No
   Eye problems or glaucoma ..... __Yes __No
   Diabetes, excessive thirst or frequent urination ..... __Yes __No
   Hepatitis, jaundice, or liver disease ..... __Yes __No
   AIDS or HIV infection ..... __Yes __No
   Thyroid problems ..... __Yes __No
   Abdominal pain or discomfort (Gastroenterological problems) ..... __Yes __No
   Persistent swollen glands in neck ..... __Yes __No
   Skin ulceration that would not heal ..... __Yes __No
   Sexually transmitted disease ..... __Yes __No
   Problems with mental health, emotional tension, depression, or anxiety ..... __Yes __No
   Cancer, Leukemia, lymphomas, or other malignant neoplasm ..... __Yes __No

6. Do you have a history of bleeding disorder? ..... __Yes __No
7. Are you allergic to any medication? ..... __Yes __No
8. Are you being treated with drugs that affect immune system, such as steroids? __Yes __No
9. Are you taking cancer treatment with x-rays or drugs? ..... __Yes __No
10. Have you ever had a low platelet count (a blood disorder)? ..... __Yes __No
11. Do you have any febrile respiratory illness? ..... __Yes __No
12. If you are female, are you pregnant? ..... __Yes __No
13. Are you receiving any blood or plasma transfusion? ..... __Yes __No
14. Do you have any previous reaction to any vaccines? ..... __Yes __No
15. Are you allergic to latex? ..... __Yes __No

I certify that I have read and understand the above questionnaire. I acknowledge that my answers provided are truthful and accurate to the best of my knowledge. I will not hold my doctor, or any other member of his/her staff, responsible for my errors or omissions that I may have made in the completion of this form.

Signature (Parent or Guardian if patient is a minor):_____

Date: _____