

Medical Exam Questionnaire



Please complete this form and take it with you when you go to the doctor, it will be retained as part of your medical report.

LAST NAME _____ FIRST NAME _____

AGE _____ SEX _____

	YES	NO
Have you ever been examined medically for a visa or a permit to enter the United States?		
Have you ever been in a hospital for any condition? List the name of the hospitals and dates that you stayed there:		
Have you ever had Tuberculosis? Any lung or chest disease? Have you ever had pleurisy?		
Have you ever had any illness requiring prolonged treatment at home or elsewhere? If so, give details:		
Have you ever suffered from trachoma or any serious eye disease?		
Have you ever suffered from blood or venereal diseases?		
Have you ever suffered from epilepsy, convulsions, seizures, fits, or fainting spells?		
Have you ever suffered from a nervous or mental condition?		

I hereby certify the above information given by me is correct.

DATE _____ SIGNATURE _____