Report of Immigration Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2025

► **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon.)

1. Your Full Legal Name (**Do not** provide a nickname)

Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. Current Physical Address

In Care Of Name (if any)

Street Number and Name | Apt. Ste. Flr. ☐ ☐ ☐ | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

3. Other Information

A. Gender ☐ Male ☐ Female

B. Date of Birth (mm/dd/yyyy)

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
► **A-**

F. USCIS Online Account Number (if any)
►

4. Immigration Medical Examination Requirement

A. ☐ I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

NEW PATIENT FORM

PLEASE COMPLETE ENTIRE FORM

Date: _____

MR: _____

Patient Information

Full Name: _____ **SS#**_____

Date of Birth (MM/DD/YYYY): _____ **Marital Status: S M D W**

Gender: ☐ Male ☐ Female ☐ Prefer not to say

Phone Number: _____

Email Address: _____

Mailing Address (where you receive YOUR mail) : _____

City: _____ **State:** _____ **ZIP:** _____

Emergency Contact Name: _____

Relationship:_____

Contact #:_____

Appointment Details:

Reason for Visit	**Brief Description / Concern**
☐ New Patient Visit	_____
☐ Immigration/I693	_____
INTERPRETER NAME AND PHONE NUMBER:	NAME: _____ PHONE # _____
☐ Pre Employment	_____
☐ Other	

My signature below gives authorization to treat the above named patient.

I authorize the physician to administer such treatment as they deem advisable for my diagnosis and condition. I understand that these services are voluntary and that I have the right to refuse these services.

I authorize Immediate Med to release any information regarding my examination or treatment for the purpose of obtaining workers compensation payments, medical records, certification or collection expenses.

When applicable, I authorize Immediate Med or my insurance company to release any information necessary to process my claims.

I understand that I may be billed for additional laboratory/radiology/office services performed but not charged today.

I agree I will be responsible for any additional fees should my account go to a collection agency.

Signature: _____ Clerk ID: _____

==========FOR OFFICE USE ONLY==========

HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____ O2:_____

Medical History

Are you under the care of a primary physician? ☐ No ☐ Yes

Name of Physician: _____ Office Name: _____

Contact #: _____

Do you currently see any other specialists?

☐ No ☐ Yes If so, list the name of they physician and the specialty you're being seen for:

_____

Medications

Are you currently taking any medications or herbal supplements? If so, please list the name, dosage and frequency below.

Medication Name	Dosage	Frequency

Allergies

Any Food or Environmental Allergies?: _____

Are you allergic to, or had a reaction to:

☐ No ☐ Yes Penicillin **☐ No ☐ Yes** Sulfa Drugs **☐ No ☐ Yes** Local Anesthetic **☐ No ☐ Yes** Soy

☐ No ☐ Yes Sulfites **☐ No ☐ Yes** Aspirin **☐ No ☐ Yes** Codeine or other narcotics **☐ No ☐ Yes** Eggs/Yolk

☐ No ☐ Yes Amoxicillin **☐ No ☐ Yes** Latex **☐ No ☐ Yes** Sodium Pentothal/Valium/ Other Tranquilizers

Other Allergies: _____

Social History

Do you smoke? ☐ No ☐ Yes → Packs/day: ____ Years? _____

Do you drink alcohol? ☐ No ☐ Yes → Drinks/week: _____

Recreational drug use? ☐ No ☐ Yes → Type/frequency: _____

Exercise regularly? ☐ No ☐ Yes → Type/how often: _____

Are you currently sexually active? ☐ Yes ☐ No

If so, you have sex with: ☐ Men ☐ Women ☐ Both

If yes, how many sexual partners have you had in the past year? ____

Do you use protection? ☐ Yes ☐ No

Have you ever had a STI? _____

For Women Only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

☐ No ☐ Yes **Is there a possibility of pregnancy?** **Expected Delivery Date If Applicable:** _____

☐ No ☐ Yes **Are you nursing?** ☐ No ☐ Yes **Are you taking birth control pills?** **Last Menstual Period?** _____

Review of Symptoms

Do you have, or have had, any of the following diseases, medical conditions, or procedures?

Symptom Category	Yes	No	Symptom Category	Yes	No
A History of Alcohol	☐	☐	Hepatitis	☐	☐
A History of Drug Abuse	☐	☐	High Blood Pressure	☐	☐
Abnormal Bleeding	☐	☐	Headache	☐	☐
Anemia	☐	☐	Infectious Mononucleosis	☐	☐
Are You on a Diet?	☐	☐	Irregular Heart Beat	☐	☐
Are You on Dialysis?	☐	☐	Jaundice/Liver Disease	☐	☐
Arthritis/Joint Pain	☐	☐	Joint Replacement	☐	☐
Asthma	☐	☐	Kidney Trouble	☐	☐
Bleeding Tendency	☐	☐	Low Blood Pressure	☐	☐
Blood Disorder	☐	☐	Low Blood Sugar	☐	☐
Blood Transfusion	☐	☐	Anxiety/Depression/Other Mental Health Issues	☐	☐
Bruise Easily	☐	☐	Mitral Valve Prolapse	☐	☐
Cancer/Radiation/Chemo	☐	☐	Osteonecrosis	☐	☐
Cardiac Pacemaker	☐	☐	Osteoporosis/Ostenopenia	☐	☐
Chest Pain/ Angina	☐	☐	Pneumonia/Bronchitis	☐	☐
Chronic Fatigue/Night Sweat	☐	☐	Problems With Immune System	☐	☐
Contact Lenses	☐	☐	Prosthetic Implant	☐	☐
Contagious Diseases	☐	☐	Respiratory Problems	☐	☐
Convulsions/ Epilepsy	☐	☐	Rheumatic Fever	☐	☐
Damaged Heart Valves	☐	☐	STI's	☐	☐
Delay In Healing	☐	☐	Sleep Apnea/CPAP	☐	☐
Diabetes	☐	☐	Snoring	☐	☐
Emphysema	☐	☐	Stomach Ulcers	☐	☐
Eye Disease/ Glaucoma	☐	☐	Stroke	☐	☐
Fainting Spells	☐	☐	Swollen Ankles	☐	☐
Gallbladder Trouble	☐	☐	Thyroid Trouble	☐	☐
GI Troubles/IBS/Colitis	☐	☐	Tuberculosis	☐	☐
Hay Fever/Sinus Problems	☐	☐	Tumor or Growths	☐	☐
Heart Attack	☐	☐	Trouble Climbing 1-2 flights of stairs	☐	☐
Heart Murmur	☐	☐	Other: _____	☐	☐
Heart Surgery	☐	☐	Other: _____	☐	☐

Please list any past surgeries, procedures, or overnight hospital stays. Include as much detail as possible.

Date	Type (Surgery / Procedure / Hospitalization)	Hospital/Facility Name	Surgeon/Physician Name	Any Complications? (Yes/No, explain if Yes)

10410 Abercorn Ext
Savannah, Ga 31419

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges that a copy of the currently effective Notice of Privacy Practices for this healthcare facility is available for review. For additional information please ask receptionist. A copy of this is signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please *print* your name **Please *sign* your name**

_____ _____

Legal Representative **Description of Authority**

Your comments regarding Acknowledgments or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FORM THE RECEPTION AREA?

☐ **First Name Only** ☐ **Proper Sir Name** ☐ **Other** _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
***(This includes step parents, grandparents, and any care takers who can have access to this patient's records*):**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENTS, & BILLING INFORMATION VIA:

☐ **Cell Phone Confirmation** ☐ **Text Message to my Cell Phone**

☐ **Home Phone Confirmation** ☐ **Email Confirmation**

☐ **Work Phone Confirmation** ☐ **ANY of the Above**

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:

☐ **Cell Phone Confirmation** ☐ **Text Message to my Cell Phone**

☐ **Home Phone Confirmation** ☐ **Email Confirmation**

☐ **Work Phone Confirmation** ☐ **ANY of the Above**

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OFFICE USE ONLY
I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:
It was an emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature _____