

*Family Medicine*  
 Heather Gjorgjievski, DO

### Immigration Health Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

PAST MEDICAL HISTORY		
	YES	NO
Have you ever been hospitalized		
Have you ever been in a Nursing Home		
Have you ever been in a Refugee Camp		
Have you ever been in a Homeless Shelter		
Have you ever been in a prison/jail		
Do you take any medications regularly		
Have you ever been treated for or exposed to anyone who has tuberculosis		
Do you have any chronic illnesses that affect the immune system (Examples: HIV, Cancer, Diabetes, Kidney Disease)		
Have you had a blistering reaction to a TB skin test		
Do you have any history of harmful behavior (Example: DUI)		
History of Alcohol Abuse		
Have you ever been treated by a mental health professional		
Have you ever been in trouble for a crime here or any other country		
Have you ever had or been treated for Chicken Pox/Varicella/Shingles		
Have you been diagnosed or treated for cancer		

LIST ALL MEDICATIONS:

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IF YES TO ANY OF THE ABOVE PLEASE PROVIDE MORE INFORMATION

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MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
<b>CONSTITUTIONAL</b>			<b>CARDIOVASCULAR</b>		
Fever			Chest Pain		
Chills			Palpitations		
Night Sweats			Syncope (passing out)		
Weight Loss			Stents		
<b>EYES</b>			Heart Attack		
Decreased or blurry vision			Congestive Heart Failure		
<b>EAR, NOSE &amp; THROAT</b>			Congenital Heart Defect		
Mouth Ulcers			Heart Rhythm Abnormality		
<b>RESPIRATORY</b>			<b>GASTROINTESTINAL</b>		
Chronic Cough			Chronic bouts of diarrhea		
Coughing up blood			Liver Disease		
Wheezing			Hepatitis		
Shortness of Breath			Intestinal Parasites		
Asthma			Inflammatory Bowel		
Bronchitis			<b>GENITAL/URINARY</b>		
Emphysema			Chronic Kidney Disease/Dialysis		
Chronic Lung Disease			Genital sores		
<b>ALLERGY IMMUNOLOGY</b>			Abnormal Discharge		
Frequent respiratory illness			<b>MUSCULOSKELETAL</b>		
Autoimmune Disorder			History of weakness/paralysis		
			Lupus		

IF YES TO ANY OF THE ABOVE PLEASE PROVIDE MORE INFORMATION:

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Medical Condition	YES	NO		Medical Condition	YES	NO
<b>INTEGUMENTARY/SKIN</b>				<b>PSYCHIATRIC</b>		
Rashes				Depression		
Sores that don't heal well				Anxiety		
<b>NEUROLOGICAL</b>				Bipolar Disorder		
Stroke				Schizophrenia		
Area(s) of numbness				Suicide Attempts		
Multiple Sclerosis				Alcoholism (or treatment for)		
Seizures/Convulsions				Mental Deficiency Handicap/Impairment		
<b>HEMATOLOGICAL,LYMPHATIC</b>				ADD/ADHD		
Leukemia				<b>WOMEN'S HEALTH</b>		
Lymphoma				Are you or do you think you could be currently pregnant		
Chronic swollen lymph nodes				<b>OTHER</b>		
<b>ENDOCRINE</b>						
Diabetes (Adult or Juvenile)						
Thyroid Disorder						
Adrenal						
Blood Sugar Problems						

IF YES TO ANY OF THE ABOVE, PLEASE PROVIDE MORE INFORMATION:

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