USCIS Medical Examination (Office Worksheet)

Applicant Information Please Type Clearly

Last Name	First Name	Full Middle Name		
Residence Address		Date of Birth	Age	Gender
City	State	Zip Code		
City Of Birth	Country of Birth	Contact Telephone Number		
Email	A-Number (if available)	Last Menstrual Period (Females)		

Health History Applicant Completes this section

Check Each Category	Yes	No	Check Each Category	Yes	No
Personal history of Tuberculosis	☐	☐	Known Heart Diseases	☐	☐
Contact with individuals sick with Tuberculosis	☐	☐	Liver disease, hepatitis	☐	☐
Sexually transmitted diseases	☐	☐	Digestive problems	☐	☐
Psychological disorders, history of harmful behavior and/or DUI History	☐	☐	Kidney disease, dialysis	☐	☐
Narcotics, Drugs or Alcohol Usage	☐	☐	**Vaccination card available for review**	☐	☐
Known Lung Diseases	☐	☐	Diabetes	☐	☐

Please list all medications used regularly:

I hereby certify that the above information is true, accurate and complete and give consent to prepare this application (form I-693)

I understand that inaccurate, false, or missing information may invalidate the examination and the Medical Examiner's Certification.

Patient Signature _____ **Date:** _____

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Physical Examination Date:

BP (mmHg)	HR (bpm)	RR (/min)	Temp (F)

	NL	ABNL		NL	ABNL
General Appearance	☐	☐	Abdomen and Viscera	☐	☐
ENT	☐	☐	Genitourinary System	☐	☐
Heart	☐	☐	Spine, other Musculoskeletal	☐	☐
Lungs	☐	☐	Neurological / Mental	☐	☐

Assessment CPE for USCIS

☐ **Normal** ☐ **Abnormal** **Notes:**

Plan - Required Labs

RPR / treponemal test
Gonorrhea NAAT (age 18-24 or indicated)
IGRA for TB (QuantiFERON-TB Gold or T-SPOT.TB)
MMR Ab (measles, mumps, rubella IgG)
VZV Ab / varicella IgG
Hepatitis B surface antibody (anti-HBs, IgG)

Mandatory Vaccinations:

Tdap / Td	Age and history dependent
Polio (IPV)	Age appropriate; ACIP catch-up guidance
MMR	If born in 1957 or later
Rotavirus	6 weeks through 8 months
Hib	2 through 59 months
Varicella	Age appropriate / valid immunity
Hepatitis B	Birth through 59 years
Hepatitis A	12 months through 18 years
Meningococcal (MenACWY)	11 through 18 years
Pneumococcal (PCV)	2 through 59 months and 65+
Influenza	6 months and older; annually when available

Follow Up in _____ days **Date (A/P):** _____ **Medical Examiner:**

Signature: _____ **Date:** _____

Notes / disposition	Billing:

☐ Form I-693 is released to patient in a sealed envelope