OMB No. 1615-0033; Expires 08/31/09

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

I-693, Report of Medical Examination and Vaccination Record

START HERE - Please type or print in CAPITAL letters (*Use black ink*)

Part 1. Information about you *(The person requesting a medical examination or vaccinations must complete this part)*

Family Name (Last Name) | Given Name (First Name) | Full Middle Name

Home Address: Street Number and Name | Apt. Number | Gender: ☐ Male ☐ Female

City | State | Zip Code | Phone # *(Include Area Code) no dashes or ()*

Date of Birth *(mm/dd/yyyy)* | Place of Birth *(City/Town/Village)* | Country of Birth | A-number *(if any)* | U.S. Social Security # *(if any)*

Applicant's Certification

I certify under penalty of perjury under United States law that I am the person who is identified in **Part 1** of this Form I-693, Report of Medical Examination and Vaccination Record, and that the information in **Part 1** of this form is true to the best of my knowledge. I understand the purpose of this medical exam, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false/altered information or documents with regard to my medical exam, I understand that any immigration benefit I derived from this medical exam may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

Signature - Do not sign or date this form until instructed to do so by the civil surgeon | **Date** *(mm/dd/yyyy)*

Part 2. Medical examination *(The civil surgeon completes this part)*

1. **Examination**

Date of First Examination | **Date(s) of Follow-up Examination(s) if Required:** Date of Exam | Date of Exam | Date of Exam

Summary of Overall Findings:

☐ No Class A or Class B Condition ☐ Class A Conditions (see **2** through **5** below) ☐ Class B Conditions (see **2** through **6** below)

2. **Communicable Diseases of Public Health Significance**

A. Tuberculosis (TB)

☐ Tuberculin Skin Test (TST) (Required for applicants 2 years of age and older: for children under 2 years of age, see pp. 11-12 of Technical Instructions at **http://www.cdc.gov/ncidod/dq/civil.htm.**)

Date TST Applied | Date TST Read | Size of Reaction *(mm)*

☐ Chest X-Ray - Required **ONLY** for TST reactions of ≥ 5mm or if specific TST exception criteria met, or for an applicant with TB symptoms or immunosuppression (e.g., HIV). **Attach copy of X-Ray Report.**

Date Chest X-Ray Taken | Date Chest X-Ray Read | Results ☐ Normal ☐ Abnormal (Describe results in remarks.)

Findings:

☐ No Class A or Class B TB ☐ Class B1 Pulmonary TB ☐ Class B2 Pulmonary TB ☐ Class B, Other Chest Condition (non-TB)

☐ Class A Pulmonary TB Disease ☐ Class B1 Extra Pulmonary TB ☐ Class B, Latent TB Infection

Remarks: (Include any signs or symptoms of TB, additional tests, and therapy given, with stop and start dates and any changes.)

Part 2. Medical Examination *(Continued)*

B. Syphilis

☐ Serologic Test for Syphilis (Required for applicants 15 years and older)

Date Screening Run

If Reactive, Date Confirmation Run

☐ Screening Nonreactive
☐ Screening Reactive, Titer 1:
☐ Confirmation Nonreactive
☐ Confirmation Reactive

Findings:

☐ No Class A or Class B Syphilis
☐ Syphilis, Class A (untreated)
☐ Syphilis, Class B (with residual deficit, treated in the past year)

Remarks: (Include any therapy given with doses and dates.)

C. HIV/AIDS

☐ Serologic Test for HIV Antibody (Required for applicants 15 years and older)

Date Screening Run

☐ Screening Negative
☐ Screening Positive
☐ Screening Indeterminate

If Positive or Indeterminate, Date Confirmation Run

☐ Confirmation Negative
☐ Confirmation Positive

Findings:

☐ No Class A HIV
☐ HIV, Class A

Remarks: (Include any signs or symptoms of HIV infection, therapy given, and any counseling, or referrals.)

D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance

Findings:

☐ Chancroid, Class A
☐ Gonorrhea, Class A
☐ Hansen's Disease (Leprosy, Infectious), Class A
☐ Granuloma Inguinale, Class A
☐ Lymphogranuloma Venereum, Class A
☐ Hansen's Disease (Leprosy, Noninfectious), Class B

Remarks: (Include any therapy given and any counseling, or referrals.)

3. Physical or Mental Disorders With Associated Harmful Behavior

☐ Physical/Mental Disorder, With Associated Harmful Behavior, Class A
☐ Physical/Mental Disorder, Without Associated Harmful Behavior, Class B

Remarks: (Include diagnosis, with likelihood of harmful behavior to recur, therapy given, and any counseling, or referrals.)

4. Drug Abuse/Drug Addiction

☐ Substance (Drug) Use, Listed in Section 202 of Controlled Substance Act, Class A
☐ Substance (Drug) Use, Not Listed in Section 202 of Controlled Substance Act, But With Associated Harmful Behavior, Class A
☐ Prior Substance (Drug) Use in Remission, Class B

Remarks: (Include any therapy given, rehabilitation, counseling, or referrals.)

Part 2. Medical examination *(Continued)*

5. **Vaccinations** (See Technical Instructions at **http://www.cdc.gov/ncidod/dq/civil.htm** for list of required vaccines.)

Vaccine History Transferred From a Written Record				Vaccine Given	Completed Series	Waiver(s) to Be Requested From USCIS			
						Blanket			
						Not Medically Appropriate			
Vaccine	Date Received mm/dd/yyyy	Date Received mm/dd/yyyy	Date Received mm/dd/yyyy	Date Given by Civil Surgeon mm/dd/yyyy	Mark an X if completed; write date of lab test if immune or "VH" if varicella history	Not Age Appropriate	Contra-indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: ☐ DT ☐ DTP ☐ DTaP									
Specify Vaccine: ☐ Td ☐ Tdap									
Specify Vaccine: ☐ OPV ☐ IPV									
MMR (Measles Mumps-Rubella) or if monovalent or other combination of the vaccines are given, specify vaccine(s):									
Hib									
Hepatitis B									
Varicella									
Pneumococcal									
Influenza									
Rotavirus									
Hepatitis A									
Meningococcal									
Human Papillomavirus									
Zoster									

Give Copy to Applicant

Results:
- ☐ Applicant may be eligible for blanket waiver(s) as indicated above.
- ☐ Applicant will request an individual waiver based on religious or moral convictions.
- ☐ Vaccine history complete for each vaccine, all requirements met.
- ☐ Applicant does not meet immunization requirements.

A-number *(if any)*

Name *(Type or print your name)*

Part 2. Medical examination *(Continued)*

6. List other medical conditions, Class B other (e.g. hypertension, diabetes)

Part 3. Referral to health department or other doctor/facility *(To be completed by Civil Surgeon, if referral was made)*

Type or Print Name of Doctor or Health Department

Date of Referral *(mm/dd/yyyy)*

Address: (Street Number and Name, City, State and Zip Code)

Daytime Phone # *(Include Area Code) no dashes or ( )*

Remarks: (Include name of medical condition and reasons for referral.)

Part 4. To Be Completed by Physician or Health Department Performing Referral Evaluation

The applicant identified on this form was referred to me by the civil surgeon named in **Part 5** of this form. I have provided appropriate evaluation/treatment.

Type or Print Full Name of Evaluating Physician or Health Department

Signature

Address: (Street Number and Name, City, State and Zip Code)

Date *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Daytime Phone # *(Include Area Code) no dashes or ( )*

Remarks: (Attach a separate sheet of paper, if needed.)

Part 5. Civil Surgeon's Certification *(Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met.)*

I certify under penalty of perjury under United States law that: I am a civil surgeon in current status designated to examine applicants seeking certain immigration benefits in the United States; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations; I performed this examination of the person identified in **Part 1** of this Form I-693, after having made every reasonable effort to verify that person whom I examined is the person identified in **Part 1**; that I performed the examination in accordance with the Centers for Disease Control and Prevention's *Technical Instructions*, and all supplemental information or updates provided to me; and that all information provided by me on this form is true and correct to the best of my information, knowledge, and belief.

Type or Print Full Name *(First, Middle, Last)*

Austin I. Ogwu MD

Signature

Address (Street Number and Name, City, State and Zip Code)

2505 West Beltline Road Lancaster Tx 75146

Date *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Alpha Medical Center

Daytime Phone # *(Include Area Code) no dashes or ( )*

(972) 230-8290

E-Mail Address

beechemjo@yahoo.com

Part 6. Health department identifying information. *(If completed by State or local health department on behalf of a refugee, place a stamp or seal where indicated.)*

Type or Print Name

Austin I. Ogwu MD

(Place State or local health department stamp/seal below.)

Signature

Date *(mm/dd/yyyy)*

Daytime Phone # *(Include Area Code) no dashes or ( )*

9722308290

Alpha Medical Center

Austin Ogwu, M.D.

Information below is for the patient being seen today

Name: _____ Today's Date: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Telephone: _____
Work Number: _____ Cell Number: _____
Date of Birth: _____ Age: _____ Circle One: Male /Female
Social Security Number: _____ Drivers License: _____
Employer: _____
Circle One: Married / Single / Divorced / Widowed Number of Children: _____

Emergency Contact: _____ Telephone: _____

Responsible Party - If patient is a minor, the adult with the patient today is:

Name: _____ Social Security Number: _____
Driver's License: _____ Circle One: Mother / Father / Guardian

Address (if different from above): _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Number: _____
Employer: _____ Work number: _____

Insured - Circle One: Mother / Father / Spouse / Self (skip below)

Name of Insured (if not the patient): _____
Date of birth: _____ Social Security # _____
Home Telephone: _____ Cell Number: _____
Employer: _____ Work number: _____

Address (if different from above): _____
City: _____ State: _____ Zip: _____

We will make a copy of your insurance card(s) for our records. Please advise us of any changes to your personal information in the future so that we may update our records.

I request that payment under my medical insurance program be made to the provider named above for services rendered to me (or my dependent child). I also authorize the above named provider to release to my insurance company any medical information needed for the claim. Further, I permit a copy of the authorization to be used in place of the original. I understand that I am financially responsible for all charges not covered by my insurance plan.

_____ _____
Patient or Responsible Party Signature Date

ALPHA MEDICAL CENTER
PATIENT PERSONAL HISTORY

Name: _____ Sex: ___ Age: _____ Date: _____
(Last name, First name)
Reason for office visit: _____

PERSONAL HISTORY (please check all that apply)

- ❑ Acid Reflux/ heart burn
- ❑ Aids / HIV
- ❑ Allergies _____
- ❑ Anemia
- ❑ Asthma
- ❑ Attention Deficit Disorder (ADD)
- ❑ Back Pain
- ❑ Blood Disease
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chest Pain
- ❑ Cough
- ❑ Circulatory Problems
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Congestive Heart Failure (CHF)
- ❑ Constipation
- ❑ Crohn's
- ❑ Depression
- ❑ Diabetes Mellitus Type_____
- ❑ Diarrhea

Last menstrual period _____ (female only)

- ❑ Difficulty Urination
- ❑ Ear Problem
- ❑ Fever
- ❑ Frequent Urination
- ❑ Glaucoma
- ❑ Gout
- ❑ Hand Pain
- ❑ Heart Problems
- ❑ Hypertension
- ❑ IBS (Irritable Bowel Sydm.)
- ❑ Joint Pain
- ❑ Leaking of Urine (Incontin.)
- ❑ Leg Pain
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Knee Pain
- ❑ Migraine Headache
- ❑ Nervous Problems
- ❑ Numbness or Tingling in the legs/Hands
- ❑ Obesity

- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Seizure
- ❑ Sexual Transmitted Disease
- ❑ Shortness of Breath
- ❑ Sickle Cell Anemia
- ❑ Sinusitis
- ❑ Sore Throat
- ❑ Stroke
- ❑ Swelling of feet or hands
- ❑ Suicide Considered
- ❑ Thyroid (Hyper or Hypo)
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary Tract Infection (UTI)
- ❑ Vomiting
- ❑ Other _____

Have you had any surgeries? (Please list what type of surgery and what year)
_____
_____

Medications- (Please list any medications currently taking including the dosage and how often taking medication)

Name of Medication	Dosage amount (mg)	How many per day

(Please list additional medications on back of this form)

Are you allergic to any medications? [] Yes [] No If yes, please list: _____

Family History- (Please list any diseases above that your immediate family member have below)

Mother-
Father-
Grandparent(s)-
Siblings-

Do you smoke tobacco? [] Yes [] No How many packs per week _____. Do you dip snuff? [] Yes [] No
Do you drink alcohol? [] Yes [] No [] Occasionally. How many per week? _____
Do you exercise? [] Yes [] No. How many times per week? _____
Social History- Marital Status: M S W D No. of Children: _____

ALPHA MEDICAL CENTER

CONSENT FOR PROCEDURE/TREATMENT FORM

I authorize and direct Alpha Medical Center, and his or her assistants as necessary to perform quality care, to perform the following procedure/treatment(s) upon me:

INS Examination and necessary immunizations And testing.

The nature and purpose of the procedure is for permanent residence in the United States of America and has been fully explained to me.

I authorize Alpha Medical Center to release any and all test results and findings to the Department of Immigration and Naturalization.

I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Alpha Medical Center
2505 W. Beltline Road
Lancaster Texas 75146
(972) 230-8290

Tuberculosis Testing Form

Patient Name: _____ Date: _____

SS#: _____ DOB: _____

(Please check one box and fill out the necessary information below)

Were you born outside the USA?	___Yes	___No
Have you had a BCG Vaccine for TB?	___Yes	___No
Have you had a persistent cough for more than 3 weeks?	___Yes	___No
Do you have recurrent night sweats?	___Yes	___No
Do you have unexplained weight loss?	___Yes	___No
Do you have unexplained fever?	___Yes	___No

By signing below I acknowledge that I have, to the best of my knowledge, answered all the above questions correctly.

_____ _____
Signature of Patient Date

To be completed by physician.

1. TB skin test (PPD). Positive _____ Negative _____

2. If positive, chest xray report done on _____
   Positive _____ Negative_____

3. Is further evaluation or treatment required?
   No _____ Yes_____

_____
Printed name of Physician

_____ _____
Signature of Physician Date

Alpha Medical Center
2505 W. Beltline Road
Lancaster, TX 75146
(972) 230-8290

Tuberculosis Testing Form

Patient Name: _____
Date: _____

(Please check one box and fill out the necessary information on the following page)

- ❑ **I have previously tested positive for TB and I understand that I am exempt from a skin test. I do agree to take a chest x-ray to determine my TB status.**
- ❑ **I agree to receive the PPD skin test (test for TB) to determine my TB status.**
- ❑ **I have had an unexpected exposure to someone with tuberculosis and agree to receive a skin test immediately.**

Method: Mantoux Skin Test

Date Test Administered: _____

Lot #: _____

Expiration Date: _____

Injection Site: _____

Health Care Professional: _____

Date Test Read: _____

Skin Test Result: _____

Health Care Professional: _____

Patient Signature _____ Date: _____