USCIS Medical History

Name: _____Date of Birth (MM/DD/YYYY)_____

Which of the following have you had or do you now have?
For "Yes" answers, on the back of the page give item number, date, treating institution, treatments, and current medical status.

1. Tuberculosis or abnormal chest-x-ray	Yes / No
2. Lived with someone who had tuberculosis	Yes / No
3. Coughed up blood	Yes / No
4. Shortness of breath	Yes / No
5. Frequent cough or night cough lasting more than 3 weeks	Yes / No
6. Persistent fever or night sweats	Yes / No
7. Eye disorder or trouble	Yes / No
8. Ear, nose, or throat trouble	Yes / No
9. Loss of vision in either eye	Yes / No
10. Loss of sensation in any body part	Yes / No
11. Swelling of a joint	Yes / No
12. Stomach trouble or ulcer	Yes / No
13. Liver trouble or jaundice	Yes / No
14. Intestinal trouble	Yes / No
15. Blood in urine	Yes / No
16. Men: urethral discharge Women: unusual vaginal discharge	Yes / No
17. Sore or ulcer on the mouth, genitals, or any other area of skin	Yes / No
18. Sexually transmitted infection such as gonorrhea or syphilis	Yes / No
19. Persistent infection	Yes / No
20. Undesired weight loss	Yes / No
21. Any enlarged lymph node	Yes / No
22. Meningitis or encephalitis	Yes / No
23. Neurological disease	Yes / No
24. Been evaluated or treated for a mental disorder	Yes / No
25. Attempted to harm yourself or another person	Yes / No
26. Alcohol use (list drinks/week and greatest number of drinks in 24 hours)	Yes / No
27. Taken drugs that were not prescribed to you (such as oxycodone or morphine?)	Yes / No
28. Used psychoactive drugs (such as cannabis, methamphetamine, heroin, cocaine, etc.)	Yes / No
29. Been a patient in any type of hospital (describe)	Yes / No
30. Been a patient in an institution for a chronic condition (mental or physical)	Yes / No

List any medications you take:

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