Brief I693

1. ***IMPORTANT*** Please enter the information EXACTLY HOW IT SHOULD BE LISTED ON YOUR I693 FORM.

First Name: _____ Middle Name: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

What is your country OF BIRTH? _____

What is your City/Town/Village OF BIRTH? _____

2. Please attach a copy of your photo ID to be used for your i693

3. What is your attached photo ID (Example: Passport, Driver License, Identification Card, Employment Authorization Card, etc.)?

○ Passport ○ Driver License ○ Identification Card
○ Instruction Permit ○ Employment Authorization Card ○ Other

If other, list identification type here:

_____

4. What is the State/Country that issued your attached photo ID?

_____

5. According to USCIS, the immigrant patient MUST be able to read, write, and understand English or the use of an interpreter is required. This can be a friend or family member over 18 years old but must be fluent in both languages. Is an interpreter needed?

○ Yes ○ No

6. What is the language that is being interpreted?

_____

7. Enter the interpreter's information

Interpreter's First Name _____ Interpreter's Last Name _____

Business or Organization (If any) _____ Interpreter's Daytime Phone Number _____

Interpreter's Mobile Phone Number (if any) _____ Interpreter's Email Address (If any) _____

8. Upload a CLEAR copy of the interpreter's Photo ID.

9. USCIS requires completion of certain vaccinations depending on age. Do you have any of your vaccination records?

○ Yes ○ No

10. Attach copies of ALL of your vaccination records for the civil surgeon to review.

11. Do you have an Alien Number (A-number) that you would like to add to your i693 form? If so, enter it now.

_____

12. Do you have a USCIS online account number that you would like to add to your i693 form? If so, enter it now.

_____

13. At Onestop Medical Clinic, we communicate regularly with patients via phone, email, and/or text messages regarding things like appointment confirmations/reminders, test results, plan of care, and health maintenance. Please provide consent to communications you would like to receive.

	I consent to receive:	I do not consent to receive:
Text Messages	Yes	No
Phone Calls	Yes	No
Email Messages	Yes	No

14. Would you like us to be able to discuss your medical condition(s) (including diagnosis, results, treatments, and care received) with a member(s) of your family?

○ Yes ○ No

15. Please list individuals (and relationship) with whom you allow us to share your health information:

	First and Last Name	Relationship
1)		
2)		
3)		

Medical History and Background

16. Have you ever had:

Heart problems?	Yes	No
Skin disease or condition?	Yes	No
Stomach or abdominal conditions?	Yes	No
Lung problems	Yes	No
HIV or AIDS	Yes	No
Hypertension (High blood pressure)?	Yes	No
Thyroid problems?	Yes	No
High cholesterol?	Yes	No
Muscle conditions?	Yes	No
Bone conditions?	Yes	No
Mental conditions?	Yes	No
Prior evidence of tuberculosis?	Yes	No
Been hospitalized for any illness or mental illness?	Yes	No

If yes to any of the above, please explain:

17. Do any of the following apply to you?

	Yes	No
Do you have a criminal record?	Yes	No
Have you or do you use narcotics or other restricted substances?	Yes	No
Are you addicted to any drug, prescription, or other substances?	Yes	No
Are you addicted to alcohol?	Yes	No

If yes to any of the above, please explain:

_____

18. OB/GYN

	Patient Response
Are you or could you possibly be pregnant?	
Are you trying to get pregnant?	
Date of last menstrual period:	

If pregnant how far along?

_____

19. Please list any medications, vitamins, or supplements you are taking (If none, write none):

	Medication Name	Dose (ex. 25mg)	Frequency (ex. daily)
1)			
2)			
3)			
4)			
5)			

If additional space is needed, list here:

_____

20. Have you ever been sexually active?

○ Yes ○ No

STD Risk Assessment Questionnaire

21. Have you been seen at an STD clinic before?

○ Yes ○ No

22. If so, when were you seen at the STD clinic?

_____

23. Have you ever been treated for STDs before?

- ○ Yes and have documentation
- ○ Yes and don't have documentation
- ○ No
- ○ Unsure

24. Do you have any of the following symptoms (If none, select none)?

- ☐ Bleeding
- ☐ Warts
- ☐ Pain
- ☐ Rash
- ☐ Itch
- ☐ Problems with urination
- ☐ Discharge
- ☐ Sores/Blisters
- ☐ None
- ☐ Other

If other, please explain:

_____

25. Have you had sex in the last 6 months?

- ○ Yes
- ○ No

26. With how many people?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10
- ○ 10 or more

27. When with new or non-steady partners, do you use a condom or barrier?

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

28. Have you had sex with:

- ☐ Men
- ☐ Women
- ☐ Both
- ☐ Other

If other, please explain

_____

29. What sex do you participate in? (Check all that apply, if none, select none)

- ☐ Oral sex
- ☐ Vaginal sex
- ☐ Anal sex
- ☐ Top (insertive)
- ☐ Bottom (receptive)
- ☐ None

30. Have you ever experienced domestic violence?

○ Yes ○ No

31. Have you ever exchanged drugs or money for sex?

○ Yes ○ No

32. Have you ever had sex with someone who you know injects drugs?

○ Yes ○ No

33. Have you ever used a needle to inject drugs?

○ Yes ○ No

34. Have you had sex with someone who you know has HIV/AIDS?

○ Yes ○ No

35. Have you used meth, speed, crank, crystal, cocaine, or crack in the last year?

○ Yes ○ No

36. Do you smoke cigarettes?

○ Yes ○ No

37. Have you ever been to jail or prison?

○ Yes ○ No

38. Do you have any tattoos?

○ Yes ○ No

39. Have you had your hepatitis B vaccine?

○ Yes ○ No ○ Unsure

40. How many HIV/AIDS tests have you had before today?

41. Have you ever been diagnosed with an STD? (Select all that apply and indicate when, if none, select non)

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital Warts
- ☐ Herpes
- ☐ Syphilis
- ☐ Non-gonococcal urethritis
- ☐ Trichomonas (Trich)
- ☐ HIV
- ☐ None
- ☐ Other

If other, please explain:

_____

42. Do your female sex partners use birth control

- ○ Yes
- ○ No
- ○ Not sure

43. If so, what birth control methods are used (If unsure, write unsure)?

_____

44. Do you use birth control?

- ○ Yes
- ○ No

Tuberculosis Screening Questionnaire

Please note: HIV infection and other medical conditions may cause a TB test to be negative, even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have a TB infection. If you have HIV infection or other medical conditions that may suppress your immune system, discuss your risk of TB with your primary care provider.

45. Have you ever been diagnosed with and treated for active tuberculosis?

- ○ Yes
- ○ No
- ○ Unsure

If yes, please provide date of diagnosis and treatment used:

_____

46. Do you currently have:

Productive cough for more than 3 weeks?	Yes	No
Fever associated with cough for more than 1 week?	Yes	No
Blood present in sputum?	Yes	No
Unexplained night sweats?	Yes	No
Unusual fatigue for more than 2 weeks?	Yes	No
Loss of appetite for more than 2 weeks?	Yes	No
Unexplained weight loss of 5 pounds or more?	Yes	No

If yes to any of the above, please explain:

_____

47. Current health status:

Do you have an acute viral infection or febrile illness?	Yes	No
Have you had a live-virus vaccine in the past 6 weeks?	Yes	No
Are you taking steroids (e.g. cortisone or prednisone)?	Yes	No
Are you currently undergoing radiation, chemo, or immunosuppressive therapy?	Yes	No

If yes to any of the above, please explain:

_____

48. History: Have you been out of the country in the past 6 months?

○ Yes ○ No

If yes, what country(s) have you traveled to?

_____

49. Have you ever had a tuberculosis (TB) skin or blood test?

○ Yes ○ No

If yes, indicated skin or blood:

_____

50. Have you ever had a positive reaction to a TB test?

○ Yes ○ No

If yes, when?

_____

51. Have you had a chest x-ray(s) related to a positive TB test?

○ Yes ○ No

if yes, when?

_____

52. Has anyone in your family been diagnosed with TB?

○ Yes ○ No ○ Unsure

If yes, when?

_____

53. Have you ever had close contact with active TB (including healthcare exposure)?

○ Yes ○ No

If yes, please explain:

_____

54. Have you ever been treated with TB medication (Including Latent TB or Active TB)?

○ Yes ○ No

If yes, please list treatment used, where treatment was received, and date completed:

_____

55. Have you ever received the BCG vaccine?

○ Yes ○ No

56. Do you have any illness which can suppress your immune system?

○ Yes ○ No

If yes, please explain:

_____