Visa Applicant Health Questionnaire

Name: ____________________

Past Medical history

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization (including psychiatric)
		Cardiology
☐	☐	Hypertension
☐	☐	Congestive heart failure or coronary artery disease
☐	☐	Arrhythmia
☐	☐	Rheumatic heart disease
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	Tobacco use: ☐ Current ☐ Former
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Tuberculosis history: Diagnosed (mm-yyyy) ______________________
		Treated (mm-yyyy)________________________________
☐	☐	Fever
☐	☐	Cough
☐	☐	Night sweats
☐	☐	Weight loss
		Psychiatry
☐	☐	Psychological/Psychiatric Disorder (including major depression, bipolar disorder, or schizophrenia)
☐	☐	Major impairment in learning, intelligence, self-care, memory, or communication
☐	☐	Use of substances other than those required for medical reasons
☐	☐	Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)
☐	☐	Substance use or substance induced disorders of substances not on the CSA (including alchohol)
☐	☐	Ever caused serious injury to others, caused major property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
☐	☐	Ever had thoughts of harming yourself
☐	☐	Ever acted on those thoughts
☐	☐	Ever had thoughts of harming others
☐	☐	Ever acted on those thoughts
		Neurology
☐	☐	History of stroke
☐	☐	Seizure disorder
☐	☐	*Current Medications* (List all current medications)

____ ____

____ ____

Name: ________________

No	Yes	*Obstetrics*
☐	☐	Pregnancy, current
		Estimated delivery date (mm-dd-yyyy) ________________
		LMP (Last Menstrual Period) __age__________________
☐	☐	Previous live births, number: ______________
		Birth dates of live births (mm-dd-yyyy)
		____________ ____________ ____________ ____________ ____________ ____________
		Sexually Transmitted Diseases
		Previous treatment for sexually transmitted disease, specify date (mm-yyyy) and treatment:
☐	☐	Syphilis ____
☐	☐	Gonorrhea ____
		Endocrinology
☐	☐	Diabetes
☐	☐	Thyroid disease
		Hematologic/Lymphatic
☐	☐	Anemia
☐	☐	Sickle Cell Disease
☐	☐	Thalassemia
☐	☐	Other hemoglobinopathy
		Other
☐	☐	An abnormal or reactive HIV blood test
		Diagnosed ______________
☐	☐	Malignancy, specify: _______________
☐	☐	Kidney or Bladder disease
☐	☐	Chronic liver disease (including hepatitis B or C)
☐	☐	Previous treatment for Hansen's Disease
		Treatment Completed (mm-yyyy) _______________
☐	☐	Other medical conditions requiring treatment, specify:
		____
☐	☐	Disabilities (including loss of arms or legs), specify:
		____
☐	☐	Have you ever been arrested or ticketed for DUI?
☐	☐	Previous Surgeries (List all previous surgeries)
		____
		____
		____
☐	☐	Did you have chickenpox in the past?
		Date of illness (mm-dd-yyyy) _________________________________

COVID- 19 Questionnaire

Name:________________________________

Are you fully vaccinated?

☐Yes:

First vaccination:_________________

Second vaccination:_______________

What type:☐Pfizer

☐Moderna

☐Astro Zeneca

☐Johnson & Johnson

☐No

Are you feeling well now?

☐Yes Current temperature : __________________℃

☐No

Do you have any contact with confirmed or probable COVID- 19 infection?

☐Yes Contact date : ______________________

☐No

Do you have COVID- 19 infection in the past?

☐No

☐Yes Confirmed date : ______________________

Recovery date : ________________________

Type of infection: ☐Asymptomatic

☐Mild infection

☐Moderate infection

☐Severe infection

☐I am in immunocompromised condition