Physician's Report Form

St Petersburg, FL
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Part 1 - - To Be Completed by Patient			
Patient Information			
Name **First Name:** **Middle Initial:** **Last Name:**			
Address Line #1			
Address Line #2			
Address Line #3			
City: **Province:** **Country:** **Postal Code:**			
Gender:	◯ Female ◯ Male		
Birth Date:			
Height:			
Weight:			
Phone Number:		**Call Time:**	
Second Phone Number:		**Call Time:**	
Next of Kin Information			
Relationship to Patient:			
Name **First Name:** **Middle Initial:** **Last Name:**			
Address Line #1			
Address Line #2			
Address Line #3			
City: **Province:** **Country:** **Postal Code:**			
Phone Number:		**Call Time:**	

Second Phone Number:		**Call Time:**

Next of Kin (Secondary) Information

Relationship to Patient:	

Name
First Name: **Middle Initial:** **Last Name:**

Address Line #1	
Address Line #2	
Address Line #3	

City: **Province:** **Country:** **Postal Code:**

Phone Number:		**Call Time:**
Second Phone Number:		**Call Time:**

Medical History

Have you ever had:

Illness	Yes	No	Illness	Yes	No
Tuberculosis	○	○	Mumps	○	○
Asthma	○	○	Rubella	○	○
Diabetes	○	○	Malaria	○	○
Kidney Disease	○	○	Chicken Pox	○	○
Heart Disease	○	○	Vision Problems	○	○
Arthritis	○	○	Glandular Fever	○	○
Epilepsy/convulsions	○	○	Ear Infections	○	○
Scarlet Fever	○	○	Chronic Headaches	○	○
Measles	○	○	Rheumatic Fever	○	○
Eating Disorder (Anorexia/Bulemia)	○	○	Clinical Depression	○	○
Anemia	○	○	Ulcers	○	○
Gall Bladder Problems	○	○	Allergies	○	○
Dizziness/Fainting	○	○	Venereal Diseases	○	○
Mental Illness	○	○	Cancer	○	○
Alcoholism	○	○	Drug Addiction	○	○

Please give details of any 'yes' answer above.
Please describe any major surgical procedures you have had and the dates of these events.
Please list any medications you are currently taking.
Please describe any physical limitations you have.
Please describe any psychiatric treatment you have received and any psychiatric limitations you have.
Please describe any chronic illnesses you have.
Have you ever been tested for AIDS? ◯ Yes ◯ No **If yes, were you diagnosed HIV positive? ◯ Yes ◯ No**

If yes, please describe all details including medication currently prescribed.

Have you ever been tested for Hepatitis? ◯ **Yes** ◯ **No**
If yes, were you diagnosed Hepatitis positive? ◯ **Yes** ◯ **No**
If yes, please describe all details including medication currently prescribed.

Part 2 - - To Be Completed by Physician

The patient for whom you are completing this form is applying for a cultural exchange program regulated by the United States' government. They will be living in a host family's home and caring for their young children. It is very important that you complete this form as carefully as possible.

Immunization Information

The patient has been immunized against the following:

Illness	Yes	No	Date
Tetanus	◯	◯	
Diphtheria	◯	◯	
Polio	◯	◯	
Measles	◯	◯	
Mumps	◯	◯	
Hepatitis A	◯	◯	
Hepatitis B	◯	◯	
Rubella (German Measles)	◯	◯	
Typhoid	◯	◯	
Tuberculin (BCG)	◯	◯	
Whooping Cough (Pertussis)	◯	◯	

System Abnormalities

System	Yes	No	Explanation
Head, Ear, Nose, and Throat	◯	◯	
Respiratory	◯	◯	
Skeletal	◯	◯	
Gastrointestinal	◯	◯	
Skin	◯	◯	
Metabolic	◯	◯	
Neuropsychiatric	◯	◯	
Eyes	◯	◯	
Genitourinary	◯	◯	
Other	◯	◯	

Explain any current treatment for this patient.	
How long have you treated this patient?	
Comments:	
Doctor Information	
Name (please print)	
Address	
Telephone	

Physician Signature_____**Date** _____