REFUGEE CLINIC INTAKE FORM

Name:_____ Patient sticker

Primary language: _____

Secondary language:_____

Country of origin:_____

Countries/refugee camps visited and how long: _____

When left country of origin: _ _____

How long in U.S.: _____

Refugee agency:_____ Case worker: _____

Past education:_____

Past employment: _____

Current employment: _____

Current housing: _____

Victim or witness of torture? Yes No

How is patient adjusting to being in the U.S. (adjustment, neglect, intimate partner violence)?

_____

Allergies: _____

Medical concerns today:

1. _____
2. _____
3. _____

Past medical history (heart, lung, abdominal problems?):

_____

_____

_____

History of tropical disease (malaria, schistosomiasis, etc.)?_____

_____

Gynecological history:_____

Past surgical history: _____

_____

_____

Medications: _____

_____

Immunizations today:

☐ Tdap ☐ Td ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Hepatitis A ☐ COVID

Screenings: _____

Vision:_____

Anemia: _____ Eosinophilia: _____

Hep B:_____ Hep C:_____

GC/CT: _____ RPR:_____

Varicella: _____

HIV:_____

Pre-arrival treatment for malaria? ☐ Yes ☐ No _____Helminths? ☐ Yes ☐ No

TB:_____ If positive CXR: _____Treatment for latent TB? ☐ Yes ☐ No

Age-appropriate: Pap (ever had one?), colon cancer, mammogram, DEXA, lipids/CMP, etc._____

_____