



U.S. Department of State  
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102  
**MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE  
FOR CHILDREN 12 YEARS AND OVER**

\*OMB APPROVAL NO. 1405-0068  
EXPIRATION DATE: xx-xx-xxxx  
ESTIMATED BURDEN: 1 HOUR

**PRIVACY ACT NOTICE:** This information is requested pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. 3084, 3901 and 3984). The primary purpose for soliciting this information is to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether federal, state, local or foreign, for law enforcement and administration purposes. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

<b>I. To Be Filled Out By Examinee</b> (complete all sections, type or in ink).		Date (mm-dd-yyyy)
1. Name of Examinee (Last, First, MI.)	2. Full Name of Employee/Applicant/Sponsor	
3. Social Security Number (Employee/Applicant/Sponsor)	4. Date of Birth (mm-dd-yyyy)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Place of Birth  City _____ State _____ Country _____	7. Status <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other	
8. Name of your Health Insurance Plan	10a. Agency of Employee/Applicant/Sponsor <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Other _____	
9. Purpose of Exam  <input type="checkbox"/> Pre-employment <input type="checkbox"/> Separation <input type="checkbox"/> In Service	10b. Type of Employment <input type="checkbox"/> Foreign Service <input type="checkbox"/> Contractor <input type="checkbox"/> Civil Service Excursion Tour	
11. Mailing Address (Medical Clearance Abstract will be mailed to listed address)  _____ _____ _____  Telephone Number (where you can be reached for the next 90 days) _____  E-mail Address (where you can be reached for the next 90 days) _____	12. Post of Assignment and Dates of Departure/Arrival a. Proposed Post _____ EDA _____ (mm-dd-yyyy) b. Present Post _____ EDD _____ (mm-dd-yyyy) c. Last 3 Posts _____ _____ _____	
13. Check and Describe Medical Conditions of Blood Relatives. Include Cancer, Alcoholism, Diabetes, Heart or Kidney Disease, High Blood Pressure, Mental Health Disorder, or Learning Disabilities.		
<input type="checkbox"/> Father _____ <input type="checkbox"/> Mother _____ <input type="checkbox"/> Grandmother(s) _____ <input type="checkbox"/> Grandfather(s) _____ <input type="checkbox"/> Sister(s) _____ <input type="checkbox"/> Brother(s) _____ <input type="checkbox"/> Aunt(s) _____ <input type="checkbox"/> Uncle(s) _____		
14. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Other	15. Are You Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**DO NOT WRITE IN THE SPACE BELOW (FOR USE BY MEDICAL DIVISION ONLY)**

Clearance Action

<b>II. Have You Had In The Past 10 Years:</b>	<b>Name of Examinee:</b>
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<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>Yes</b></td> <td style="width:10%;"><b>No</b></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1. Frequent or severe headaches?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2. Dizzy spells, fainting, or seizures?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3. Neurological disorders?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4. Chronic eye trouble, or vision problems? Date of last eye exam: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5. Tooth or gum problems?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6. 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<p><b>Women Only</b></p> <p><input type="checkbox"/> <input type="checkbox"/> 41. Do you have menstrual cycles? Date of last menstrual period _____</p> <p><input type="checkbox"/> <input type="checkbox"/> 42. Have you had an abnormal PAP test in the last 5 years? Date of last PAP test _____ Date of abnormal PAP test _____ Result _____</p>	<p><input type="checkbox"/> <input type="checkbox"/> 43. Have you ever had a mammogram?</p> <p><input type="checkbox"/> <input type="checkbox"/> 44. Have you ever had breast implants?</p> <p><input type="checkbox"/> <input type="checkbox"/> 45. Are you pregnant?</p> <p><input type="checkbox"/> <input type="checkbox"/> 46. Are you nursing?</p> <p style="text-align: center;"><b>Pregnancy History:</b> (number of times)</p> <p>Pregnant _____ Miscarriages _____ Live births _____ Premature births _____ Abortions _____ Living children _____</p>
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III. Hospitalizations/Operations/Medical Evacuations (Include All Medical and Psychiatric Illnesses)			
Date (mm-dd-yyyy)	Illness or Operation	Name of Hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please Recheck All Items for Completeness and Accuracy. DO NOT INDICATE: "Previously Answered."**

**IV. Explanations required for "yes" answers to questions 40 to 43 and 47 to 51. Attach additional sheet.**  
 The intentional omission of any crucial medical information is a criminal offense (Section 1001 of the U.S.C. Title 18). Pre-employment applicants who intentionally omit information which would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause if they are hired. Current employees may also be subject to disciplinary action for intentional omission of information.

<b>Signature of Examinee</b> (I certify I have read and understand the above statements).	<b>Date</b> (mm-dd-yyyy)
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**V. Examiner Comments on Significant History and Examination Findings: Comment on all items checked YES in section II.**

<b>VI. To Be Completed By The Examiner</b>		<b>Name Of Examinee:</b>		
1. Race (check one) (needed for genetic risk factors) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other (specify) _____	2. Height _____ in. or _____ cm.	3. Weight _____ lbs. or _____ kgs.	4. Pulse _____	5. Blood Pressure (sitting) If above 140/85 repeat 3 times and record. If consistently elevated consider treatment.
<b>VII. Clinical Evaluation</b>				<b>Notes</b>
Check each item as indicated. Check "NE" if not evaluated.				(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)
	Normal	Abnormal	NE	
1. General/Constitution				
2. Skin				
3. Eyes				
4. Ears/Nose/Throat				
5. Neck/Thyroid				
6. Lungs/Thorax				
7. Breasts				
8. Cardiovascular				
9. Abdomen				
10. Male Genitalia				
11. Anus/Rectum/Prostate				
12. Musculoskeletal				
13. Lymphatic				
14. Neurological				
15. Female Gynecologic				
16. Miscellaneous				
17. Papanicolaou done <input type="checkbox"/> Not done <input type="checkbox"/> Reason if not done				
18. Attach cytology report.				
<b>VIII. List Current Medications (Include prescription, over the counter, vitamins, and herbals)</b>				Drug Or Other Allergies
_____				_____
_____				_____
_____				_____
_____				_____
<b>IX. Instructions</b>				
<p><b>Disposition of Records:</b>          All reports must be in English and identified with the full name and date of birth of the examinee.          Do Not Submit Reports by US Mail.          Do Not Submit Reports by Professional Courier Service (e.g. FedEx or DHL).          Keep originals as a permanent record.</p> <p><b>For U.S. Department of State Health Units:</b>          The preferred method to submit the DS-1843 is by way of eForms to Medical Records. If this is not possible, please submit the completed document by FAX.</p> <p><b>For Private Health Care Providers:</b>          Please FAX the completed DS-1843 directly to Medical Records.</p> <p>Department of State, Medical Records:          FAX: (703) 875-5414 or (703) 875-4850</p> <p>Please confirm the report was received by sending an e-mail to MedMr@state.gov</p>				

