U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

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

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
FOR CHILDREN 12 YEARS AND OVER

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.

I. To Be Filled Out By Examinee *(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 ☐ Male ☐ Female

6. Place of Birth

City _____ State _____ Country _____

7. Status ☐ Applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other

8. Name of your Health Insurance Plan

9. Purpose of Exam ☐ Pre-employment ☐ Separation ☐ In Service

10a. Agency of Employee/Applicant/Sponsor ☐ State ☐ USAID ☐ Other _____

10b. Type of Employment ☐ Foreign Service ☐ Contractor ☐ 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.

☐ Father _____
☐ Mother _____
☐ Grandmother(s) _____
☐ Grandfather(s) _____
☐ Sister(s) _____
☐ Brother(s) _____
☐ Aunt(s) _____
☐ Uncle(s) _____

14. Marital Status ☐ Married ☐ Never Married ☐ Other

15. Are You Adopted? ☐ Yes ☐ No

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

Clearance Action

***Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/ISS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.**

II. Have You Had In The Past 10 Years:	Name of Examinee:

Yes	No		Yes	No	
☐	☐	1. Frequent or severe headaches?	☐	☐	20. Rheumatologic-problems; tendon, joint or back pain/injury; bone-deformity or fracture?
☐	☐	2. Dizzy spells, fainting, or seizures?	☐	☐	21. Malaria or other tropical disease?
☐	☐	3. Neurological disorders?	☐	☐	22. Any hair, nail or skin problems or disorders?
☐	☐	4. Chronic eye trouble, or vision problems? Date of last eye exam: _____	☐	☐	23. Diabetes; thyroid or other hormonal/metabolic disease?
☐	☐	5. Tooth or gum problems?	☐	☐	24. Anemia or blood transfusion?
☐	☐	6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?	☐	☐	25. Have you ever had an organ transplant or been an organ donor?
☐	☐	7. Cough, wheezing, shortness of breath or asthma?	☐	☐	26. Recent gain or loss of 10 lbs or more?
☐	☐	8. Abnormal chest X-ray	☐	☐	27. Thickening or lump in breast, testicle or elsewhere?
☐	☐	9. History of positive TB skin test or clinical tuberculosis, TB exposure, or BCG vaccination?	☐	☐	28. Felt unusually depressed, sad, blue or had frequent crying spells?
☐	☐	10. Palpitations, chest pressure, murmurs or any other heart problems?	☐	☐	29. Difficulty in relaxing or calming down; felt panicky, irritable, angry, hyper or nervous?
☐	☐	11. History of aneurysm or blood clots?	☐	☐	30. Special education needs?
☐	☐	12. High blood pressure or hypercholesterolemia?	☐	☐	31. Have you ever used tobacco products?
☐	☐	13. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?	☐	☐	32. Have you ever used alcohol?
☐	☐	14. Hernia?	☐	☐	33. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years?
☐	☐	15. Have you had a colonoscopy or sigmoidoscopy? Date _____	☐	☐	34. Have you ever been referred to or received mental health treatment?
☐	☐	16. A change in urinary habits, urinary tract infection or stones, blood or protein in urine?	☐	☐	35. Do you practice safe sex?
☐	☐	17. Sexually-transmitted disease?	☐	☐	36. Are you at risk for AIDS?
☐	☐	18. Serious infection?	☐	☐	37. Do you exercise?
☐	☐	19. Cancer of any type?	☐	☐	38. Are you careful with your diet?
			☐	☐	39. Do you have a living will?
			☐	☐	40. Other?

Women Only

☐	☐	41. Do you have menstrual cycles? Date of last menstural period _____	☐	☐	43. Have you ever had a mammogram?
☐	☐	42. Have you had an abnormal PAP test in the last 5 years?	☐	☐	44. Have you ever had breast implants?
			☐	☐	45. Are you pregnant?
			☐	☐	46. Are you nursing?

Date of last PAP test _____

Date of abnormal PAP test _____

Result _____

Pregnancy History: *(number of times)*

Pregnant _____ Miscarriages _____ Live births _____

Premature births _____ Abortions _____ Living children _____

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.

Signature of Examinee *(I certify I have read and understand the above statements).*	Date *(mm-dd-yyyy)*

V. Examiner Comments on Significant History and Examination Findings: Comment on all items checked YES in section II.

VI. To Be Completed By The Examiner		Name Of Examinee:		
1. Race *(check one)* *(needed for genetic risk factors)* ☐ White ☐ Black ☐ 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.

VII. Clinical Evaluation Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	Notes *(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)*
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. Micellaneous				
17. Papanicolaou done ☐ Not done ☐ Reason if not done				
18. Attach cytology report.				

VIII. List Current Medications *(Include prescription, over the counter, vitamins, and herbals)*	Drug Or Other Allergies

IX. Instructions

Disposition of Records:
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.

For U.S. Department of State Health Units:
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.

For Private Health Care Providers:
Please FAX the completed DS-1843 directly to Medical Records.

Department of State, Medical Records:
FAX: (703) 875-5414 or (703) 875-4850

Please confirm the report was received by sending an e-mail to MedMr@state.gov

X. All Tests Required Unless Otherwise Specified. Please Attach All Reports.

Name of Examinee:

1. Hematology

Hematocrit _____ %
or
Hemoglobin _____ gms%
WBC _____ /cmm

Differential

Granulocytes _____ %
Lymphocytes _____ %
Eosinophils _____ %
Other _____ %

7. Urinalysis *(pre-employment, separation and when indicated)*

Specific Gravity _____
Albumin _____
Sugar _____
WBC _____
RBC _____
Casts _____

2. Screening Chemistry *(pre-employment and at least every 5 years)*

Blood Sugar _____
Cholesterol _____
HDL/LDL _____
Triglycerides _____
Creatinine _____
ALT _____
GGT _____
HbA1C *(when indicated)* _____

8. ECG *(50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings).*

Results

9. Chest X-Ray *(required for persons 18 years and over for pre-employment and separation, for new TB skin test converters or when indicated. If pregnant, baseline chest X-ray required after delivery)*

Date *(mm-dd-yyyy)* _____ Results _____

3. Serology *(specify test and results) (12 years and over for pre-employment and approx. every 5 years after)*

RPR/VDRL _____
HIV I/II antibody _____
HepB surface antigen _____
HepC antibody _____

10. Tuberculin Test *(5TU PPD) (recommended for all examinees including those with previous BCG)*

Date *(mm-dd-yyyy)* _____
If Not Done, Explain _____
Results: _____ mm of Induration
Previous Positive Yes _____ No _____
Previous Rx Complete Yes _____ No _____
Date Completed *(mm-dd-yyyy)* _____
New Converter Yes _____ No _____
(X-Ray required)

Treatment

11. Pre-employment and in Service if not previously done. *(not for separation)*

a. Blood Type
ABO _____
(Rh) D _____
(weak) D^{u} _____

b. G6PD
Normal _____
Deficient _____

4. Stool Exam for Occult Blood *(50 years or earlier when indicated)*

a. Pos _____ Neg _____
b. Pos _____ Neg _____
c. Pos _____ Neg _____

5. Colon Screen

(age 50 or when indicated by risk factors according to current standards of care)

FFS, Barium Enema, or Colonoscopy.

Attach most recent results.

6. PSA *(50 years or earlier when indicated.)*

12. Mammogram *(required age 50 years and over, recommended age 40 and over)*

XI. Assessment Or Problem List

XII. Recommendation for Treatment/Further Study/Consultation or Follow-Up

Typed Name of Examiner

Signature

Date *(mm-dd-yyyy)*

Examining Facility
Telephone Number _____
Fax Number _____

Address