



**PRE-EMPLOYMENT MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
FOR INDIVIDUALS AGE 12 AND OLDER**

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 <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	10b. Type of Employment <input type="checkbox"/> Foreign Service <input type="checkbox"/> Contractor <input type="checkbox"/> Civil Service Excursion Tour	
11. Your 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 _____ _____ _____	

To the Doctor: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

II. Have You Had In The Past 10 Years:

Name of Examinee: _____

Yes No

- 1. Frequent or severe headaches?
- 2. Dizzy spells, fainting, or seizures?
- 3. Neurological disorders?
- 4. Chronic eye trouble, or vision problems?
Date of last eye exam (mm-dd-yyyy) _____
- 5. Tooth or gum problems?
- 6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?
- 7. Cough, wheezing, shortness of breath or asthma?
- 8. Abnormal chest X-ray
- 9. History of positive TB skin test or clinical tuberculosis, TB exposure, or BCG vaccination?
- 10. Palpitations, chest pressure, murmurs or any other heart problems?
- 11. History of aneurysm or blood clots?
- 12. High blood pressure or hypercholesterolemia?
- 13. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?
- 14. Hernia?
- 15. Have you had a colonoscopy or sigmoidoscopy?
Date (mm-dd-yyyy) _____
- 16. A change in urinary habits, urinary tract infection or stones, blood or protein in urine?
- 17. Sexually-transmitted disease?
- 18. Serious infection?
- 19. Cancer of any type?

Yes No

- 20. Rheumatologic-problems; tendon, joint or back pain/injury; bone-deformity or fracture?
- 21. Malaria or other tropical disease?
- 22. Any hair, nail or skin problems or disorders?
- 23. Diabetes; thyroid or other hormonal/metabolic disease?
- 24. Anemia or blood transfusion?
- 25. Have you ever had an organ transplant or been an organ donor?
- 26. Recent gain or loss of 10 lbs or more?
- 27. Thickening or lump in breast, testicle or elsewhere?
- 28. Felt unusually depressed, sad, blue or had frequent crying spells?
- 29. Difficulty in relaxing or calming down; felt panicky, irritable, angry, hyper or nervous?
- 30. Special education needs?
- 31. Have you ever used tobacco products?
- 32. Have you ever used alcohol?
- 33. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years?
- 34. Have you ever been referred to or received mental health treatment?
- 35. Do you practice safe sex?
- 36. Are you at risk for AIDS?
- 37. Do you exercise?
- 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 menstrual period _____
- 42. Have you had an abnormal PAP test in the last 5 years?
Date (mm-dd-yyyy) of last PAP test _____
Date (mm-dd-yyyy) of abnormal PAP _____

- 43. Have you ever had a mammogram?
- 44. Have you ever had breast implants?
- 45. Are you pregnant?
- 46. Are you nursing?

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 1 to 46. 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) <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.
VII. Clinical Evaluation				Notes
Check each item as indicated. Check "NE" if not evaluated.				(Describe every abnormality in detail. Include 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.				
VIII. List Current Medications (Include prescription, over the counter, vitamins, and herbals)				Drug Or Other Allergies
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
IX. Instructions				
<p>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.</p> <p>For U.S. Department of State Health Units and Private Health Care Providers: The preferred method to submit the DS-1843P is to scan and send by email to: MEDMR@state.gov. If it is not possible to scan, then please FAX the DS-1843P to Medical Records at Fax: 703-875-4850.</p> <p>Please confirm the report was received by sending an e-mail to MEDMR@state.gov.</p>				

X. All Tests Required Unless Otherwise Specified. Please attach all reports.		Name of Examinee: _____	
1. Hematology		7. Urinalysis (<i>pre-employment, separation and when indicated</i>)	
Hematocrit _____ % or Hemoglobin _____ gms%	Differential Granulocytes _____ % Lymphocytes _____ % Eosinophils _____ % Other _____ %	Specific Gravity _____	WBC _____
WBC _____ /cmm		Albumin _____	RBC _____
		Sugar _____	Casts _____
2. Screening Chemistry (<i>pre-employment and at least every 5 years</i>)		8. ECG (<i>50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings.</i>)	
Blood Sugar _____	Creatinine _____	Results _____	
Cholesterol _____	ALT _____	9. Chest X-Ray (<i>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</i>)	
HDL/LDL _____	GGT _____	Date (<i>mm-dd-yyyy</i>) _____ Results _____	
Triglycerides _____	HbA1C (<i>when indicated</i>) _____	10. Tuberculin Test (<i>5TU PPD</i>) (<i>recommended for all examinees including those with previous BCG</i>)	
3. Serology (<i>specify test and results</i>) (<i>12 years and over for pre-employment and approx. every 5 years after</i>)		11. Pre-employment and in Service if not previously done. (<i>not for separation</i>)	
RPR/VDRL _____	HIV I/II antibody _____	Date (<i>mm-dd-yyyy</i>) _____	a. Blood Type
HepB surface antigen _____	HepC antibody _____	If Not Done, Explain _____	ABO _____
4. Stool Exam for Occult Blood (<i>50 years or earlier when indicated</i>)		Results: _____ mm of Induration	(Rh) D _____
5. Colon Screen (<i>age 50 or when indicated by risk factors according to current standards of care</i>)		Previous Positive _____ Yes _____ No	(weak) D ^u _____
a. _____ Pos _____ Neg	FFS, Barium Enema, or Colonoscopy.	Previous Rx Complete _____ Yes _____ No	b. G6PD
b. _____ Pos _____ Neg	Attach most recent results.	Date Completed (<i>mm-dd-yyyy</i>) _____	Normal _____
c. _____ Pos _____ Neg		New Converter (<i>X-Ray required</i>) _____ Yes _____ No	Deficient _____
6. PSA (<i>50 years or earlier when indicated.</i>)		12. Mammogram (<i>required age 50 years and over, recommended age 40 and over</i>)	
XI. Assessment Or Problem List		XII. Recommendation for Treatment/Further Study/Consultation or Follow-Up	
Typed Name of Examiner _____		Signature _____	Date (<i>mm-dd-yyyy</i>) _____
Examining Facility _____ Telephone Number _____ Fax Number _____		Address _____	