



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 INDIVIDUALS AGE 12 AND OLDER

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 04-30-2012
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.

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 7. Status
City _____ State _____ Country _____
 Applicant Spouse Daughter
 Son Other

8. Name of your Health Insurance Plan 10a. Agency of Employee/Applicant/Sponsor
 State USAID Other _____

9. Purpose of Exam 10b. Type of Employment
 Pre-employment Separation In Service
 Foreign Service Contractor 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 _____
ED _____
(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

As part of this examination, you may be asked for Family Medical History. Providing this information is strictly voluntary and will only be used for diagnosis and treatment, and only by medical providers in MED. Medical clearance decisions do not take into account Family Medical History, but only manifest diseases and medical conditions.

Signature _____
Date (mm-dd-yyyy)

VI. To Be Completed By The Examiner		Name Of Examinee:			
1. Race (check one) <i>(needed for genetic risk factors)</i> <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		Normal	Abnormal	NE	Notes <i>(Describe every abnormality in detail. Include pertinent item number before each comment.)</i>
Check each item as indicated. Check "NE" if not evaluated.					
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 <i>(Include prescription, over the counter, vitamins, and herbals)</i>				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: 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>For Private Health Care Providers: Please FAX the completed DS-1843 directly to Medical Records.</p> <p>Department of State, Medical Records: It is best to scan and send by email to MEDMR@state.gov.</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	Differential	7. Urinalysis (pre-employment, separation and when indicated)	
Hematocrit _____ % or Hemoglobin _____ gms%	Granulocytes _____ % Lymphocytes _____ % Eosinophils _____ % Other _____ %	Specific Gravity _____	WBC _____
WBC _____ /cmm		Albumin _____	RBC _____
		Sugar _____	Casts _____
2. Screening Chemistry (pre-employment and at least every 5 years)		8. ECG (50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings.)	
Blood Sugar _____	Creatinine _____	Results _____	
Cholesterol _____	ALT _____	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)	
HDL/LDL _____	GGT _____	Date (mm-dd-yyyy) _____ Results _____	
Triglycerides _____	HbA1C (when indicated) _____	10. Tuberculin Test (5TU PPD) (recommended for all examinees including those with previous BCG)	
3. Serology (specify test and results) (12 years and over for pre-employment and approx. every 5 years after)		Date (mm-dd-yyyy) _____	
RPR/VDRL _____		If Not Done, Explain _____	
HIV I/II antibody _____		Results: _____ mm of Induration	
HepB surface antigen _____		Previous Positive _____ Yes _____ No _____	
HepC antibody _____		Previous Rx Complete _____ Yes _____ No _____	
		Date Completed (mm-dd-yyyy) _____	
4. Stool Exam for Occult Blood (50 years or earlier when indicated)	5. Colon Screen (age 50 or when indicated by risk factors according to current standards of care)	New Converter (X-Ray required) _____ Yes _____ No _____	
a. _____ Pos _____ Neg	FFS, Barium Enema, or Colonoscopy.	Treatment _____	
b. _____ Pos _____ Neg	Attach most recent results.	11. Pre-employment and in Service if not previously done. (not for separation)	
c. _____ Pos _____ Neg		a. Blood Type	
		ABO _____	
		(Rh) D _____	
		(weak) D ^u _____	
		b. G6PD	
		Normal _____	
		Deficient _____	
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 _____	