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

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EXPIRATION DATE: 04-30-2012
ESTIMATED BURDEN: 1 HOUR

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 ☐ 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

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

10b. Type of Employment ☐ 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 _____
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		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 *(mm-dd-yyyy)* _____	☐	☐	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 *(mm-dd-yyyy)* _____	☐	☐	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 menstrual 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 *(mm-dd-yyyy)* of last PAP test _____

Date *(mm-dd-yyyy)* of abnormal PAP _____

_____

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)* ☐ 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. Include 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. Miscellaneous				
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 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.

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 _____ %

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

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

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 _____

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.)*

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

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

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 _____

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 _____

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