U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No Yes

General

- ☐ ☐ Illness or injury requiring hospitalization *(including psychiatric)*

Cardiology

- ☐ ☐ Heart disease
- ☐ ☐ Hypertension *(high blood pressure)*
- ☐ ☐ Cardiac arrhythmia

Pulmonology

- ☐ ☐ History of tobacco use
  Current use ☐ Yes ☐ No
- ☐ ☐ Asthma
- ☐ ☐ Chronic obstructive pulmonary disease *(emphysema)*
- ☐ ☐ History of tuberculosis *(TB)* disease
  Treated ☐ Yes ☐ No
  Current TB symptoms ☐ Yes ☐ No

Neurology and Psychiatry

- ☐ ☐ History of stroke, with current impairment
- ☐ ☐ Seizure disorder
- ☐ ☐ Major impairment in learning, intelligence, self care, memory, or communication
- ☐ ☐ Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
- ☐ ☐ Use of drugs other than those required for medical reasons
- ☐ ☐ Addiction or abuse of specific* substance *(drug)*
  *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
- ☐ ☐ Other substance-related disorders *(including alcohol addiction or abuse)*
- ☐ ☐ Ever taken action to end your life

No Yes

- ☐ ☐ Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

- ☐ ☐ Pregnancy
  Last menstrual period Date *(mm-dd-yyyy)* _____
- ☐ ☐ Sexually transmitted diseases, specify _____

Endocrinology and Hematology

- ☐ ☐ Diabetes mellitus
- ☐ ☐ Thyroid disease
- ☐ ☐ History of malaria

Other

- ☐ ☐ Malignancy, specify _____
- ☐ ☐ Chronic renal disease
- ☐ ☐ Chronic hepatitis or other chronic liver disease
- ☐ ☐ Hansen's Disease
  ☐ Multibacillary ☐ Paucibacillary
  Treated ☐ Yes ☐ No
- ☐ ☐ Visible disabilities *(including loss of arms or legs)*, specify

_____

_____

- ☐ ☐ Other requiring treatment, specify

_____

_____

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

_____

_____

_____

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ /____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*		N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status	☐	☐	☐	Genitalia *(including circumcision, infection(s))*
☐	☐	☐	Hearing and ears	☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Eyes	☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Nose, mouth, and throat *(include dental)*	☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Breast				
☐	☐	☐	Lungs	☐	☐	☐	Lymph nodes
☐	☐	☐	Abdomen *(including liver, spleen)*	☐	☐	☐	Nervous system *(including nerve enlargement)*
			Fundal height _____ cm	☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form)* _____

☐ For continuing other treatment, specify _____

5. Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

Public reporting burden for this collection of information is estimated to average 35 minutes 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/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.

CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.