U.S. Department of State

Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

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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. 4084, 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. The information requested is voluntary however 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. eMED Number if known *(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

10. Agency of Employee/Applicant/Sponsor

☐ State ☐ USAID ☐ Foreign Commercial Service

☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

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.

***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/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202.**

II. Have You Had In The Past 5 Years: | **Name of Examinee:**

Yes	No	Question
☐	☐	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 high cholesterol ?
☐	☐	13. Esophagus, stomach, intestinal, rectal, liver, gallbladder problems or hernia?
☐	☐	14. Have you had a colonoscopy or sigmoidoscopy? Date *(mm-dd-yyyy)* ________
☐	☐	15. A change in urinary habits, urinary tract infection or stones, blood or protein in urine?
☐	☐	16. Sexually-transmitted disease?
☐	☐	17. Serious infection?
☐	☐	18. Cancer of any type?
☐	☐	19. Rheumatologic-problems; tendon, joint or back pain/injury; bone-deformity or fracture?
☐	☐	20. Malaria or other tropical disease?
☐	☐	21. Any hair, nail or skin problems or disorders?
☐	☐	22. Diabetes; thyroid or other hormonal/metabolic disease?
☐	☐	23. Anemia or blood transfusion?
☐	☐	24. Have you ever had an organ transplant or been an organ donor?
☐	☐	25. Recent gain or loss of 10 lbs or more?
☐	☐	26. Thickening or lump in breast, testicle or elsewhere?
☐	☐	27. Felt unusually depressed, sad, blue or had frequent crying spells?
☐	☐	28. Difficulty in relaxing or calming down; felt panicky, irritable, angry, hyper or nervous?
☐	☐	29. Special education needs?
☐	☐	30. Have you ever used tobacco products?
☐	☐	31. Have you ever used alcohol?
☐	☐	32. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years?
☐	☐	33. Have you ever been referred to or received mental health treatment?
☐	☐	34. Do you practice safe sex?
☐	☐	35. Are you at risk for AIDS?
☐	☐	36. Do you exercise?
☐	☐	37. Are you careful with your diet?
☐	☐	38. Do you have a living will?
☐	☐	39. Any other concerns you would like to address with the clinician?

Women Only

Yes	No	Question
☐	☐	40. Do you have menstrual cycles? Date of last menstrual period ________
☐	☐	41. Have you had an abnormal PAP test in the last 5 years?
☐	☐	42. Have you ever had a mammogram?
☐	☐	43. Are you pregnant?
☐	☐	44. 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 44. 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. Height ________ in. or ________ cm.	2. Weight ________ lbs. or ________ kgs.	3. Pulse	4. 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:
Examinee or sponsor must sign on page 2. Medical provider must sign on page 4.
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.
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.

If you wish to confirm that your exam forms were received please email 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 ________

Cholesterol ________

HDL/LDL ________

Triglycerides ________

Creatinine ________

ALT ________

GGT ________

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 *(if known HBsAb positive or has had immunization, do not repeat)* ________

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)*

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 ________

Albumin ________

Sugar ________

WBC ________

RBC ________

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)* (mm-dd-yyyy) ________

New Converter *(X-Ray required)* ________ Yes ________ No

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