|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | Name *(Last, First, MI.)* | | | | | | Exam Date *(mm-dd-yyyy)* |
| Birth Date *(mm-dd-yyyy)* | Passport Number | | | | Alien (*Case*) Number | |
| **1. Past Medical History** | | | | | | | | | |
| No | Yes |  | | | No | Yes |  | | |
|  |  | **General**  Illness or injury requiring hospitalization (including psychiatric)  **Cardiology**  Hypertension  Congestive heart failure or coronary artery disease  Arrhythmia  Rheumatic heart disease  Congenital heart disease  **Pulmonology**  Tobacco use: Current Former  Asthma  Chronic obstructive pulmonary disease  Tuberculosis history: Diagnosed *(mm-yyyy)*  Treated *(mm-yyyy)*  Fever  Cough  Night sweats  Weight loss  **Psychiatry**  Major impairment in learning, intelligence, self-care, memory, or communication  Major mental disorder (including bipolar disorder, major depression, mental retardation, post-traumatic stress disorder, schizoaffective disorder, schizophrenia)  Use of drugs other than those required for medical reasons  Addiction (dependence) or abuse of specific substances or drugs on the CSA  Other substance related disorders (including alcohol abuse or dependence)  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  Ever had thoughts of harming yourself  Ever acted on those thoughts  Ever had thoughts of harming others  Ever acted on those thoughts  **Neurology**  History of stroke  Seizure disorder  **Applicant appears to be providing unreliable or false information, specify in remarks** | | |  |  | **Obstetrics and Sexually Transmitted Diseases**  Pregnancy, current  Estimated delivery date *(mm-dd-yyyy)*  Pregnancy, birth dates *(mm-dd-yyyy)*  **Previous treatment for sexually transmitted diseases, specify date *(mm-yyyy)* and treatment:**  Chancroid  Gonorrhea  Granuloma inguinale  Lymphogranuloma venereum  Syphilis  **Endocrinology**  Diabetes mellitus  Thyroid disease  **Hematologic/Lymphatic**  Anemia  Sickle Cell Disease  Thalassemia major  Other hemoglobinopathy  **Other**  HIV: if previously tested, mm-yyyy of test  Wears glasses or contact lenses  Malignancy, specify:  Chronic renal disease  Chronic liver disease (including hepatitis)  Hansen’s Disease: Diagnosed *(mm-yyyy)*  Treated *(mm-yyyy)*  Other medical conditions requiring treatment, specify:  Disabilities (including loss of arms or legs), specify: | | |
| **2. Current Medications** *(List all current medications)* | | | | | **3. Previous Surgeries** *(List all previous surgeries)* | | | | |



**Photo**

OMB No. 1405-0113

EXPIRATION DATE: xx/xx/xxxx

ESTIMATED BURDEN: 30 minutes

*(See Page 2 – Back of Form)*

U.S. Department of State

**MEDICAL HISTORY AND**

**PHYSICAL EXAMINATION WORKSHEET**

For Use with DS-2054

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4. Vital Signs and Vision**  Height cm  Weightkg  BMI kg/m2 | | | BP /  Pulse / min | | Temperature ○C  Respiratory  Rate / min | | | Visual acuity at 20 feet:  Uncorrected L 20/ R 20/  Corrected L 20/ R 20/ |
| **5. Physical Examination** *(include all findings and give details in Remarks)*  **N, normal; A, abnormal** | | | | | | | | |
| **N** | **A** |  | | **N** | | **A** |  | |
|  |  | General appearance  Nutritional status *(including acute wasting and or chronic stunting malnutrition)*  Hearing and ears  Eyes  Nose, mouth, and throat *(include detail)*  Heart *(S1, S2, murmur, rub)*  Lungs  Abdomen *(including liver, spleen)*  Genitalia *(including infection(s))* | |  | |  | Inguinal region *(including adenopathy)*  Musculoskeletal system *(including gait)*  Extremities *(including pulses, edema)*  Skin *(including hypopigmentation or anesthesia consistent with Hansen’s Disease, evidence of self-inflicted injury or injections)*  Hematologic *(including signs of anemia such as pallor, koilonychia)*  Lymph nodes  Nervous system *(including nerve enlargement)*  Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)* | |
| **6. Mental Health Specialist**  Referral made to mental health specialist. If so, attach report. | | | | | | | | |
| **7. Syphilis Laboratory Results and Treatment**  Laboratory testing not done   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | **Test Name** | | **Date specimen obtained *(mm-dd-yyyy)*** | | | **Positive** | **Negative** | **Initial Titer** | | **Screening** | |  | |  | | |  |  |  | | **Confirmatory** | |  | |  | | |  |  |  | | Treated  Yes  No | If treated, therapy:  Benzathine penicillin, 2.4 MU IM  Other *(therapy, dose)*: | | | | | | Date(s) treatment given *(mm-dd-yyyy)* | | | | Treated by panel physician: | | | | Yes | No | | Stage of syphilis *(mark one)*:  Primary  Secondary  Early latent  Late latent or latent of unknown duration | | Tertiary  Neurosyphilis  Congenital | | | | | | | | | | | | |
| **8. Diagnosis and Treatment of Other Sexually Transmitted Infections**  Infection: Chancroid Gonorrhea Granuloma inguinale Lymphogranuloma venereum  Diagnosed by panel physician: Yes No Treated by panel physician: Yes No   |  |  |  |  | | --- | --- | --- | --- | | Drug | Dosage | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* | |  |  |  |  | |  |  |  |  | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **9. Diagnosis and Treatment for Hansen’s Disease** | | |
| Type of Hansen’s Disease  Multibacillary  Paucibacillary  Treated by panel physician  Yes  No | Treatment  Partial  Completed | |  |  |  |  | | --- | --- | --- | --- | | Drug | Dosage | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| If not treated by panel physician, was referral made by panel physician to another provider for treatment:  Yes. Provide facility name:  No | | |
| Diagnosis  Initial diagnosis made by panel physician  Initial diagnosis made by non-panel physician before medical evaluation by panel physician  If so, year of diagnosis: | | |
| **10. Remarks** | | |
| **PAPERWORK REDUCTION ACT STATEMENT**  Public reporting burden for this collection of information is estimated to average 30 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: [PRA\_BurdenComments@state.gov](mailto:PRA_BurdenComments@state.gov)  **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, in the discretion of the Secretary of State, 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. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records. | | |