

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

<b>1. Past Medical History</b>					
No	Yes		No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	<b>General</b> Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Obstetrics and Sexually Transmitted Diseases</b> Pregnancy, current Estimated delivery date (mm-dd-yyyy) _____ Pregnancy, birth dates (mm-dd-yyyy) _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiology</b> Hypertension <input type="checkbox"/> Congestive heart failure or coronary artery disease <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Rheumatic heart disease <input type="checkbox"/> Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>Previous treatment for sexually transmitted diseases, specify date (mm-yyyy) and treatment:</b> <input type="checkbox"/> Chancroid _____ <input type="checkbox"/> Gonorrhea _____ <input type="checkbox"/> Granuloma inguinale _____ <input type="checkbox"/> Lymphogranuloma venereum _____ <input type="checkbox"/> Syphilis _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Pulmonology</b> Tobacco use: <input type="checkbox"/> Current <input type="checkbox"/> Former Asthma Chronic obstructive pulmonary disease Tuberculosis history: Diagnosed (mm-yyyy) _____ Treated (mm-yyyy) _____ Fever Cough Night sweats Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrinology</b> Diabetes mellitus Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatry</b> 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	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic/Lymphatic</b> Anemia Sickle Cell Disease Thalassemia major Other hemoglobinopathy
<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurology</b> History of stroke Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> 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: _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Applicant appears to be providing unreliable or false information, specify in remarks</b>	<input type="checkbox"/>	<input type="checkbox"/>	Disabilities (including loss of arms or legs), specify: _____ _____

**2. Current Medications (List all current medications)**

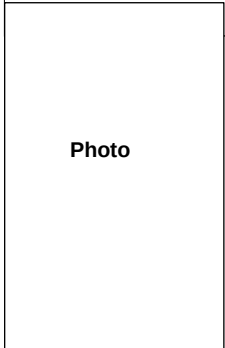
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**3. Previous Surgeries (List all previous surgeries)**

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\_\_\_\_\_



U.S. Department of State

## MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For Use with DS-2054

OMB No. 1405-0113  
EXPIRATION DATE: xx/xx/xxxx  
ESTIMATED BURDEN: 30 minutes  
(See Page 2 – Back of Form)

DRAFT6

<b>4. Vital Signs and Vision</b>					
Height _____ cm	Drug _____	BP _____	Dosage _____ / _____	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)
Weight _____ kg		Pulse _____ / min		Temperature _____ °C	Visual acuity at 20 feet:
BMI _____ kg/m <sup>2</sup>					Uncorrected L 20/ _____ R 20/ _____
				Respiratory Rate _____ / min	Corrected L 20/ _____ R 20/ _____

**5. Physical Examination** (include all findings and give details in Remarks)

**N, normal; A, abnormal**

N	A		N	A	
<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional status (including acute wasting and or chronic stunting malnutrition)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation or anesthesia consistent with Hansen's Disease, evidence of self-inflicted injury or injections)
<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include detail)	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic (including signs of anemia such as pallor, koilonychia)
<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)			Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including infection(s))			

**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
<b>Screening</b>					
<b>Confirmatory</b>					
Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	If treated, therapy: <input type="checkbox"/> Benzathine penicillin, 2.4 MU IM <input type="checkbox"/> Other (therapy, dose): _____		Date(s) treatment given (mm-dd-yyyy)		
	Treated by panel physician: <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Stage of syphilis (mark one): <input type="checkbox"/> Primary <input type="checkbox"/> Tertiary <input type="checkbox"/> Secondary <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Early latent <input type="checkbox"/> Congenital <input type="checkbox"/> Late latent or latent of unknown duration				

**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

**9. Diagnosis and Treatment for Hansen's Disease**

Type of Hansen's Disease	Treatment	Drug	Dosage	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)
<input type="checkbox"/> Multibacillary	<input type="checkbox"/> Partial				
<input type="checkbox"/> Paucibacillary	<input type="checkbox"/> Completed				
Treated by panel physician					
<input type="checkbox"/> Yes					
<input type="checkbox"/> No					

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**

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**PAPERWORK REDUCTION ACT STATEMENT**

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**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.