	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			**Obstetrics and Sexually Transmitted Diseases**
☐	☐	Illness or injury requiring hospitalization (including psychiatric)	☐	☐	Pregnancy, current
					Estimated delivery date *(mm-dd-yyyy)* _____
		Cardiology	☐	☐	Pregnancy, birth dates *(mm-dd-yyyy)*
☐	☐	Hypertension			_____ _____ _____
☐	☐	Congestive heart failure or coronary artery disease			
☐	☐	Arrhythmia			_____ _____ _____
☐	☐	Rheumatic heart disease			
☐	☐	Congenital heart disease			**Previous treatment for sexually transmitted diseases, specify date *(mm-yyyy)* and treatment:**
		Pulmonology	☐	☐	Chancroid _____
☐	☐	Tobacco use: ☐ Current ☐ Former	☐	☐	Gonorrhea _____
☐	☐	Asthma	☐	☐	Granuloma inguinale _____
☐	☐	Chronic obstructive pulmonary disease	☐	☐	Lymphogranuloma venereum _____
☐	☐	Tuberculosis history: Diagnosed *(mm-yyyy)* _____	☐	☐	Syphilis _____
☐	☐	Treated *(mm-yyyy)* _____			
☐	☐	Fever			**Endocrinology**
☐	☐	Cough	☐	☐	Diabetes mellitus
☐	☐	Night sweats	☐	☐	Thyroid disease
☐	☐	Weight loss			
					Hematologic/Lymphatic
		Psychiatry	☐	☐	Anemia
☐	☐	Major impairment in learning, intelligence, self-care, memory, or communication	☐	☐	Sickle Cell Disease
			☐	☐	Thalassemia major
☐	☐	Major mental disorder (including bipolar disorder, major depression, mental retardation, post-traumatic stress disorder, schizoaffective disorder, schizophrenia)	☐	☐	Other hemoglobinopathy
					Other
☐	☐	Use of drugs other than those required for medical reasons	☐	☐	HIV: if previously tested, mm-yyyy of test _____
☐	☐	Addiction (dependence) or abuse of specific substances or drugs on the CSA	☐	☐	Wears glasses or contact lenses
			☐	☐	Malignancy, specify: _____
☐	☐	Other substance related disorders (including alcohol abuse or dependence)	☐	☐	Chronic renal disease
			☐	☐	Chronic liver disease (including hepatitis)
☐	☐	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	☐	☐	Hansen's Disease: Diagnosed *(mm-yyyy)* _____
			☐	☐	Treated *(mm-yyyy)* _____
			☐	☐	Other medical conditions requiring treatment, specify:
☐	☐	Ever had thoughts of harming yourself			_____
☐	☐	Ever acted on those thoughts			
☐	☐	Ever had thoughts of harming others			_____
☐	☐	Ever acted on those thoughts			
			☐	☐	Disabilities (including loss of arms or legs), specify:
		Neurology			_____
☐	☐	History of stroke			
☐	☐	Seizure disorder			_____
☐	☐	**Applicant appears to be providing unreliable or false information, specify in remarks**			

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

_____

_____

_____

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

_____

_____

_____

Photo

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

4. Vital Signs and Vision

Drug	Dosage	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
Height _____ cm	BP _____ / _____	Temperature _____ ○C	Visual acuity at 20 feet:
Weight _____ kg	Pulse _____ / min	Respiratory Rate _____ / min	Uncorrected L 20/ _____ R 20/ _____ Corrected L 20/ _____ R 20/ _____
BMI _____ kg/m2			

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

N, normal; A, abnormal

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

Treated
☐ Yes
☐ No

If treated, therapy:
☐ Benzathine penicillin, 2.4 MU IM
☐ Other *(therapy, dose)*: _____

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

Date(s) treatment given *(mm-dd-yyyy)*

_____ _____ _____

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
- ☐ Multibacillary
- ☐ Paucibacillary

Treatment
- ☐ Partial
- ☐ Completed

Drug	Dosage	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*

Treated by panel physician
- ☐ Yes
- ☐ 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

_____

_____

_____

_____

_____

_____

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

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.