U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: xx-xx-xxxx
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

FOR INDIVIDUALS AGE 12 AND OLDER

PRIVACY ACT NOTICE

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (22 U.S.C. §§ 4084, 3901, 3984).

PURPOSE: The information solicited on this form will be used to make appropriate medical clearance decisions.

ROUTINE USES: The information on this form maybe shared with personnel in the Office of Medical Services. Unless otherwise protected by medical privacy regulations, the information 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. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary. However, failure to provide the information requested on this form may result in denial of a medical clearance. Also, if you are an applicant to the Foreign Service, your failure to provide the information requested on this form may affect your Foreign Service eligibility.

PAPERWORK REDUCTION ACT STATEMENT: 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: M/MED/EX, Room L217 SA-1, U.S. Department of State, Washington, DC 20522

I. To Be Filled Out By Examinee *(Complete all sections, type or in ink.)*

1. Name of Examinee *(Last, First, MI.)*

Date *(mm-dd-yyyy)*

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/Employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other

8. Name of your Health Insurance Plan

9. Purpose of Exam

☐ Separation ☐ In Service ☐ 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 (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 _____

ED _____ *(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.

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

Yes No

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?

Primary Care PTSD Screen

This questionnaire is intended to help you identify if you have the symptoms of Post-Traumatic Stress Disorder (PTSD). Please answer the following four questions if you have been assigned to a danger pay post in the last three years.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you:

34. Have had nightmares about it or thought about it when you did not want to?
35. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
36. Were constantly on guard, watchful, or easily startled?
37. Felt numb or detached from others, activities, or your surroundings?

Women Only

38. Do you have menstrual cycles?
    Date of last menstrual period _____
39. Have you had an abnormal PAP test in the last 5 years?
    Date *(mm-dd-yyyy)* of last PAP test _____
    Date *(mm-dd-yyyy)* of abnormal PAP _____
    Result _____
40. Have you ever had a mammogram?
41. Are you pregnant?
42. Are you nursing?

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 42. 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.

For U.S. Department of State Health Units:
The preferred method to submit the DS-1843 is by way of eForms to Medical Records. If this is not possible, please submit the completed document by FAX.

For Private Health Care Providers:
Please FAX the completed DS-1843 directly to Medical Records.

Department of State, Medical Records:
The preferred method to submit the DS-1843 is to scan and send by email to: MEDMR@state.gov.
If it is not possible to scan, then please fax the DS-1843 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 _____ %

6. Urinalysis *(when indicated)*

Specific Gravity _____
Albumin _____
Sugar _____
WBC _____
RBC _____
Casts _____
_____

2. Screening Chemistry *(pre-employment and at least every 5 years)*

Blood Sugar _____
Cholesterol _____
HDL/LDL _____
Triglycerides _____
Creatinine _____
ALT _____
GGT _____
HbA1C *(when indicated)* _____

7. ECG *(50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings.)*

Results

8. 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 _____

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 pos. or has had immunization, do not repeat)* _____
HepC antibody _____

9. 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 _____ Yes _____ No
(X-Ray required)

Treatment

11. Pre-employment and in Service if not previously done. *(not for separation)*

a. Blood Type
ABO _____
(Rh) D ^{u} _____
(weak) D _____

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.

5. Mammogram *(required age 50 years or when indicated by risk factors according to current standards of care. Attachment most recent result)*

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