



U.S. Department of State  
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102  
**MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE**  
FOR INDIVIDUALS AGE 12 AND OLDER

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

**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 <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Status <input type="checkbox"/> Applicant/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other
6. Place of Birth City _____ State _____ Country _____		
8. Name of your Health Insurance Plan		10. Agency of Employee/Applicant/Sponsor <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Foreign Commercial Service <input type="checkbox"/> Foreign Agricultural Service <input type="checkbox"/> Board of Broadcasting Governors
9. Purpose of Exam <input type="checkbox"/> Separation <input type="checkbox"/> In Service <input type="checkbox"/> Pre-Employment		
11. Your Mailing Address (Medical Clearance Abstract will be mailed to listed address.) _____ _____ <i>Telephone Number (where you can be reached for the next 90 days)</i> _____ <i>E-mail (where you can be reached for the next 90 days)</i> _____		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.

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequent or severe headaches?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Dizzy spells, fainting, or seizures?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Neurological disorders?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Chronic eye trouble, or vision problems?<br>Date of last eye exam (mm-dd-yyyy) _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Tooth or gum problems?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?    |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Cough, wheezing, shortness of breath or asthma?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Abnormal chest X-ray  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. History of positive TB skin test or clinical tuberculosis, TB exposure, or BCG vaccination? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Palpitations, chest pressure, murmurs or any other heart problems?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. History of aneurysm or blood clots?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. High blood pressure or high cholesterol ?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Esophagus, stomach, intestinal, rectal, liver, gallbladder problems or hernia?             |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you had a colonoscopy or sigmoidoscopy?<br>Date (mm-dd-yyyy) _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. A change in urinary habits, urinary tract infection or stones, blood or protein in urine?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Sexually-transmitted disease?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Serious infection?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Cancer of any type?  |

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Rheumatologic-problems; tendon, joint or back pain/injury; bone-deformity or fracture?     |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Malaria or other tropical disease?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Any hair, nail or skin problems or disorders?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Diabetes; thyroid or other hormonal/metabolic disease?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Anemia or blood transfusion?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever had an organ transplant or been an organ donor?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Recent gain or loss of 10 lbs or more?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Thickening or lump in breast, testicle or elsewhere?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Felt unusually depressed, sad, blue or had frequent crying spells?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. Difficulty in relaxing or calming down; felt panicky, irritable, angry, hyper or nervous?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. Special education needs?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you ever used tobacco products?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever used alcohol?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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:**

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

**Women Only**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 38. Do you have menstrual cycles?<br>Date of last menstrual period _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you had an abnormal PAP test in the last 5 years?<br>Date (mm-dd-yyyy) of last PAP test _____<br>Date (mm-dd-yyyy) of abnormal PAP _____<br>Result _____ |

- |                          |                          |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you ever had a mammogram? |
| <input type="checkbox"/> | <input type="checkbox"/> | 41. Are you pregnant?              |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

<b>Signature of Examinee</b> (I certify I have read and understand the above statements).	Date (mm-dd-yyyy)
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**V. Examiner Comments on Significant History and Examination Findings: Comment on all items checked YES in section II.**

<b>VI. To Be Completed By The Examiner</b>		<b>Name Of Examinee:</b>			
1. Height _____ in. or _____ cm.	2. Weight _____ lbs. or _____ kgs.	3. Pulse	4. Blood Pressure ( <i>sitting</i> ) If above 140/85 repeat 3 times and record. If consistently elevated consider treatment.		
<b>VII. Clinical Evaluation</b> Check each item as indicated. Check "NE" if not evaluated.		Normal	Abnormal	NE	<b>Notes</b> (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 <input type="checkbox"/> Not done <input type="checkbox"/> Reason if not done					
18. Attach cytology report.					
<b>VIII. List Current Medications</b> (Include prescription, over the counter, vitamins, and herbals)				Drug Or Other Allergies	
_____				_____	
_____				_____	
_____				_____	
<b>IX. Instructions</b>					
<p><b>Disposition of Records:</b>  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.</p> <p><b>For U.S. Department of State Health Units:</b>  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.</p> <p><b>For Private Health Care Providers:</b>  Please FAX the completed DS-1843 directly to Medical Records.</p> <p><b>Department of State, Medical Records:</b>  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.</p> <p>If you wish to confirm that your exam forms were received please email MEDMR@state.gov</p>					

<b>X. All Tests Required Unless Otherwise Specified. Please attach all reports.</b>		<b>Name of Examinee:</b> _____	
<b>1. Hematology</b> Hematocrit _____ % or Hemoglobin _____ gms% WBC _____ /cmm  <b>Differential</b> Granulocytes _____ % Lymphocytes _____ % Eosinophils _____ % Other _____ %	<b>6. Urinalysis (when indicated)</b> Specific Gravity _____ WBC _____ Albumin _____ RBC _____ Sugar _____ Casts _____		
<b>2. Screening Chemistry (pre-employment and at least every 5 years)</b> Blood Sugar _____ Creatinine _____ Cholesterol _____ ALT _____ HDL/LDL _____ GGT _____ Triglycerides _____ HbA1C (when indicated) _____		<b>7. ECG (50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings.)</b> Results _____	
<b>3. Serology (specify test and results) (12 years and over for pre-employment and approx. every 5 years after)</b> RPR/VDRL _____ HIV I/II antibody _____ HepB surface antigen (if known HBsAb pos. or has had immunization, do not repeat) _____ HepC antibody _____		<b>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)</b> Date (mm-dd-yyyy) _____ Results _____	
<b>4. Stool Exam for Occult Blood (50 years or earlier when indicated)</b> a. _____ Pos _____ Neg b. _____ Pos _____ Neg c. _____ Pos _____ Neg	<b>9. Tuberculin Test (5TU PPD) (recommended for all examinees including those with previous BCG)</b> 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) _____ New Converter _____ Yes _____ No (X-Ray required) Treatment _____		
<b>5. Colon Screen (age 50 or when indicated by risk factors according to current standards of care)</b> Barium Enema, or Colonoscopy. Attach most recent results.		<b>11. Pre-employment and in Service if not previously done. (not for separation)</b> a. Blood Type ABO _____ (Rh) D <sup>u</sup> _____ (weak) D _____	
<b>5. Mammogram (required age 50 years or when indicated by risk factors according to current standards of care. Attachment most recent result)</b>			
<b>XI. Assessment Or Problem List</b>		<b>XII. Recommendation for Treatment/Further Study/Consultation or Follow-Up</b>	
Typed Name of Examiner _____		Signature _____	Date (mm-dd-yyyy) _____
Examining Facility Telephone Number _____ Fax Number _____		Address _____	