

U.S Department of State
Bureau of Medical Services, M/MED, Room L101, SA-1, Washington, DC 20522- 0102
OVERSEAS PRE-ASSIGNMENT MEDICAL HISTORY AND EXAMINATION
Non-Foreign Service Personnel and Their Family Members

OMB APPROVAL NO. xxxx
EXPIRATIONDATE: XX/XX/XXXX
ESTIMATED BURDEN: 1 hour*

PRIVACY ACT STATEMENT

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

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

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. More information on routine uses can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary; however, not providing requested information may result in the failure of the individual to obtain the requisite medical clearance pursuant to 16 FAM 211.

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 recommendation for reducing it, please send them to: M/MED/EX, Room L101 SA-1, U.S. Department of state, Washington, DC 20522

I. DEMOGRAPHIC INFORMATION

DATE OF EXAM: *(mm-dd-yyyy)*

TO BE FILLED OUT BY EXAMINEE (OR PARENT for EXAMINEE < 18 y/o)

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

2. If Eligible Family Member, Name of Employee:

3. U.S. Govt. Agency and Branch:

4. Date of Birth: *(mm-dd-yyyy)*

5. Sex: Female
 Male

6. Status: Employee Spouse Dependent Child Domestic Partner

7. EMPLOYMENT STATUS:

- Civil Service WAE PSC Contractor / Bureau or Office: _____
 Locally Engaged Staff DOD Civilian DOD Contractor
 Contractor (include name of contracting company and assoc. USG Agency): _____

8. Post of Assignment Estimated Dates of Arrival/ Departure (if known)

a. Proposed Post(s): _____
EDA: _____ (mm-dd-yyyy)

b. Present Post: _____
EDD: _____ (mm-dd-yyyy)

9. Details of Assignment: (please check all that apply)

- Frequent TDY
 Iraq
 AFG
 Other ESCAPE Post/Name _____
 Other: _____

10. Email Address of examinee or parent of child < 18 y/o:
(Where you can be reached for the next 90 days):

11. Telephone number: (patient or dependent ≥ 18 years of age):
(Where you can be reached for the next 90 days)

To the individual and/or health care provider completing the medical history review /exam: 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 members' 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.

NAME OF EXAMINEE:	DOB:
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II. MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS: For YES answers, provide a brief explanation, attach additional pages if needed.

<p>Do you (or your child) have a history of: (parents - please answer for children < 18 years of age)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 1. Frequent/severe headaches or migraines?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 2. Fainting or dizzy episodes?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 3. Stroke, TIA or head injury?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 4. Epilepsy, seizures or other neurologic disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 5. Chronic eye or vision problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 6. Ear, nose, throat problems; hearing loss, hoarseness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 7. Allergies or history of anaphylactic reaction?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 8. Shortness of breath, asthma, or COPD?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 9. History of abnormal chest x-ray?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 10. History of positive TB skin test or tuberculosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 11. Aneurysm, blood clot or pulmonary embolism?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 12. High blood pressure?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 13. Heart problems, murmur or palpitations?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 14. Have you smoked any cigarettes in the last month?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 15. Stomach, esophageal, intestinal problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 16. Jaundice or hepatitis (type)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 17. Intestinal, rectal problems or hernia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 18. Urinary or kidney problems, blood in urine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 19. Diabetes or thyroid disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 20. Joint or back pain/injury?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No 21. Rheumatologic disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 22. Anemia?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 23. Blood transfusion?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 24. Malaria or other tropical disease?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 25. Any skin or nail disorder?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 26. Cancer of any type?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 27. Any thickening or lump in breast, testicle?</p>
<p><input type="checkbox"/> Yes <input type="checkbox"/> No 28. Have you consumed at any one time in the past year, more than 5 alcohol drinks for males or 4 drinks for females? Explain.</p> <p style="text-align: center;">IN THE PAST SEVEN (7) YEARS (for questions 29-33)</p> <p>(parents - please answer for children < 18 years of age)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 29. Have you used marijuana, amphetamines, narcotics, cocaine, or hallucinogenic drugs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 30. Have you been in psychotherapy/counseling or been prescribed medication for depression, anxiety, mood or stress?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 31. Have you felt unusually depressed, sad, blue, or had frequent crying spells which lasted more than two weeks at a time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 32. Have you had frequent or recurrent episodes of: difficulty in relaxing or calming down, panicky feelings, irritability, anger, feeling hyper, or nervousness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 33. Have you experienced any emotional or physical symptoms related to a past trauma?</p>	

Children Only Yes No 34. Has your child been referred for any current or potential special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)? Explain:

<p>Women: (provide results if applicable, N/A if not applicable)</p> <p>35. Date of last PAP test? _____ Results: _____</p> <p>36. Date of last Mammogram? _____ Results: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 37. Are you pregnant? Est. due date: _____</p>	<p>Men/Women: Colon Cancer Screening:</p> <p>38. Date of last colon cancer screening? If applicable _____</p> <p>Test (colonoscopy/sigmoidoscopy/guacFOBT): _____</p> <p>Results: _____</p>
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For all applicants, employees or eligible family members:

39. Is there any other medical or mental health condition not covered in questions 1 – 38? Yes No Explain:

IIA: Explanations required for “yes” answers to questions 1 – 39. Attach Additional sheets as needed.

III. List Current Medications (include prescription, over the counter, vitamins and herbs)	Drug or Other Allergies
_____	_____
_____	_____
_____	_____

IV. Hospitalizations / Operations / Medical Evacuations: (Include all medical and psychiatric illnesses/hospitalizations)

Date (mm-dd-yyyy)	Illness, Operation, Medevac	Name of Hospital	City and State, Country
_____	_____	_____	_____
_____	_____	_____	_____

Any knowing and willful omission, falsification, or fraudulent statement regarding material medical information may constitute a criminal offense under 18 U.S.C. § 1001, and individuals committing such an offense may be subject to criminal prosecution. Employees of the United States Government also may be subject to disciplinary action, up to and including separation, for any knowing and willing omission or falsification or fraudulent statement of material information.

Signature of Examinee/ (Parent for children under age 18) (I certify that I have read and I understand the above statements	Date: (mm-dd-yyyy)
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NAME OF EXAMINEE:	DOB:
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IX. LABORATORY ANALYSIS

**All tests are required unless otherwise specified. Results from previous 12 months are acceptable.
COPIES OF LABORATORY REPORTS MUST BE SUBMITTED FOR REVIEW AND MUST BE IN ENGLISH**

1a. Hematology Tests: Ages 1 year to 11 years Hematocrit _____% Or Hemoglobin _____gms%	2. Chemistry (ages 12 and older) Fasting Blood sugar _____ HgA1C (if indicated) _____ Creatinine _____ ALT _____	3. Serology (ages 12 and older) HIV I/II antibody _____
1b. Hematology Tests: Ages 12 years and older Hematocrit _____% Or Hemoglobin _____gms% WBC _____/cmm Platelets _____		

4. Tuberculin Skin Test: Required for ages 1 and over (unless previously positive) Results: _____ mm of induration Date: _____ <i>Interferon Gamma Release Assay: (may substitute for TST if ≥ 5 y/o or</i> In those with previous BCG) Results: _____ Date: _____ <i>If no TB screening performed, explain why:</i> Previous active tuberculosis <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____ Date: _____ Previous positive TST or IGRA <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____ Date: _____ Previous LTBI treatment <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____ Date: _____ Hx of BcG vaccine <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____ Date: _____ Other: _____	5. Chest X Ray: (PA and lateral) - submit report <ul style="list-style-type: none"> Required for those with ≥ 10 mm TST newly identified or if positive IGRA <li style="text-align: center;">OR When clinically indicated Results: _____ Date: _____
	6. ECG (50 years or older, earlier if indicated) submit tracing Results: _____ Date: _____

OPTIONAL TESTS: *The following tests may be performed at the discretion of the Examiner, with patient consent. They are not required for a medical clearance determination. If performed, results may be used in the provision of care to individuals covered under the Department of State Medical Program.*

7. Blood Type: (if not previously documented) Type: ABO _____ (Rh) Dμ: _____ (weak D): _____
8. G6PD: (If not previously documented) for malarial prophylaxis Results : _____ Date: _____
9. Blood lead level: (recommended screening ages 12 months to 5 years) Results : _____ Date: _____

X. Assessment or Problem List	XI. Recommendation for Treatment / Further Study / Consultation or Follow - Up
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Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
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Examining Facility Address	Telephone Number
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