



# OVERSEAS PRE-ASSIGNMENT MEDICAL HISTORY AND EXAMINATION Non-Foreign Service Personnel and Their Family Members

### 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

<b>I. DEMOGRAPHIC INFORMATION TO BE FILLED OUT BY EXAMINEE (OR PARENT for EXAMINEE &lt; 18 Y/O)</b>	<b>DATE OF EXAM (mm-dd-yyyy)</b>
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female

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): \_\_\_\_\_  
 LNA       Other: \_\_\_\_\_

8. Post of Assignment and Estimated Dates of Arrival / Departure (if known)  a. Proposed Post: _____ EDA (mm-dd-yyyy)  b. Present Post: _____ EDD (mm-dd-yyyy)	9. Details of Assignment (Check all that apply) <input type="checkbox"/> Frequent TDY <input type="checkbox"/> Iraq <input type="checkbox"/> AFG <input type="checkbox"/> Other ESCAPE Post/Name: _____ <input type="checkbox"/> Other: _____ _____ _____
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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 of examinee or parent of child < 18 y/o (Where you can be reached for the next 90 days)
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**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.**

<b>Name of Examinee</b>	<b>DOB</b>
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**II. MEDICAL HISTORY**

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

<p><b>Do you (or your child) have a history of:</b> (parents - please answer for children &lt; 18 years of age)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1. Frequent/severe headaches or migraines?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2. Fainting or dizzy episodes?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3. Stroke, TIA or head injury?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4. 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**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><b>Women:</b> (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 Are you pregnant? Est. due date: _____</p>	<p><b>Men/Women: Colon Cancer Screening:</b> (provide results if applicable, N/A if not applicable)</p> <p>38. Date of last colon cancer screening, if applicable: _____</p> <p>Test (colonoscopy/sigmoidoscopy/guicFOBT): _____</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.**

<b>III. LIST OF CURRENT MEDICATIONS</b> (Include prescription, over the counter, vitamins, and herbs)	<b>Drug Or Other Allergies</b>

<b>IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS</b> (Include all medical and psychiatric illnesses)			
Date (mm-dd-yyyy)	Illness or Operation	Name of Hospital	City and State

**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.**

<b>V. SIGNATURE OF EXAMINEE OR PARENT OF CHILD &lt;18 Y/O</b> (I certify I have read and understand the above statement.)	Date (mm-dd-yyyy)

Name of Examinee	DOB
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**V. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF FORM DS-6561**

**MEDICAL EXAMINER**

- Medical Examiner must comment on positive history on page 2. Medical Examiner must comment on physical findings and provide recommendations for treatment/further study/consultations of medical & mental health problems.
- Medical Examiner must sign on page 4.

**EXAMINEE / SPONSOR / PARENT**

- All fields on page 1 and 2 must be filled out. Examinee or parent/employee sponsor must sign on page 2.
- Submit copies of all laboratory tests and additional medical reports with DS-6561.
- All Lab tests and medical reports must be in English, and identified with full name and date of birth of examinee.
- Keep originals as a permanent record. Do NOT submit by U.S. Mail or by courier service (e.g. FedEx or DHL). The preferred method to submit the DS - 6561 (and supporting documentation) is to scan and email in PDF format to: **MEDMR@state.gov**. If it is not possible to scan, please fax to Medical Records department **FAX: 703-875-4850**. If you wish to confirm that your exam forms were received, please email **MEDMR@state.gov**.

**VI: Medical Examiner comments on significant patient medical history and items checked "yes" on page 2/section II. Use additional pages, if needed.**

**VII: Clinical Evaluation: *Newborn exam cannot be accepted if completed before four (4) weeks of age***

1. Height  _____ in. or _____ cm.	2. Weight  _____ lbs. or _____ kgs	3. BMI	4. Pulse	5. Blood Pressure ( <i>sitting</i> ) If above 140/85 repeat 3 times and record.
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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. Mental / Affect / Mood / ( <i>Development-children</i> )				
3. Skin				
4. Eye				
5. Ears/Nose/Throat				
6. Neck/Thyroid				
7. Lungs/Thorax				
8. Breasts				
9. Cardiovascular ( <i>Record murmurs/abnormalities</i> )				
10. Abdomen				
11. Male Genitalia				
12. Anus/Rectum/Prostate ( <i>if indicated</i> )				
13. Musculoskeletal / Spine / Extremities ( <i>Note limitations</i> )				
14. Lymph Nodes				
15. Neurologic				
16. Female Gynecologic ( <i>if indicated</i> )				

<b>Name of Examinee</b>		<b>DOB</b>	
<b>IX. LABORATORY ANALYSIS: All tests are required unless otherwise specified. Test results from previous 12 months are acceptable. COPIES OF LABORATORY REPORTS MUST BE SUBMITTED FOR REVIEW AND MUST BE IN ENGLISH</b>			
<b>1. Hematology: Ages 1 year to 11 years</b>	<b>1a. Hematology : Ages 12 years and older</b>	<b>2. Chemistry Ages 12 years and older</b>	<b>3. Serology Ages 12 years and older</b>
Hematocrit _____% <b>or</b> Hemoglobin _____gms%	Hematocrit _____% <b>or</b> Hemoglobin _____gms%  WBC _____ /cmm  Platelets _____	Fasting Blood Sugar _____  HgA1C ( <i>if indicated</i> ) _____  Creatinine _____  ALT _____	HIV I/II Antibody _____
<b>4. Tuberculin Skin Test: Required for ages 1 and over (unless previously positive)</b>		<b>5. Chest X Ray (PA and lateral) - submit report</b>	
Results: _____ mm of induration      Date: _____ <i>Interferon Gamma Release Assay: (may substitute for TST if &gt; 5 y/o or In those with previous BCG)</i> Results: _____      Date: _____ If no TB screening performed, explain why: 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: _____		• <b>Required for those with &gt; 10 mm TST newly identified or if positive IGRA</b> <b>OR</b> • <b>When clinically indicated</b> Results: _____      Date: _____	
		<b>6. ECG (50 years or older, earlier if indicated) - submit tracing</b>	
		Results: _____ Date: _____	
<b>OPTIONAL TESTS:</b> 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.			
<b>7. Blood Type ( if not previously documented)</b> Type: ABO _____ (Rh) D <sub>p</sub> : _____ (weak D): _____			
<b>8. G6PD (If not previously documented)</b> for malarial prophylaxis      Results: _____      Date: _____			
<b>9. Blood lead level (recommended screening ages 12 months to 5 years)</b> Results: _____      Date: _____			
<b>X. Assessment or Problem List</b>		<b>XI. Recommendation for Treatment / Further Study / Consultation or Follow - Up</b>	
Typed Name of Examiner		Signature of Examiner	Date (mm-dd-yyyy)
Examining Facility		Telephone Number	
Address			