U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: XX/XX/XXXX
ESTIMATED BURDEN: 15 minutes
(See Page 2 - Back of Form)

Photo

Surnames	Given Names	Exam Date *(mm-dd-yyyy)*

Birth Date *(mm-dd-yyyy)*	Document Type	Document Number	Case or Alien Number

1. Medical History (*Past or present*)

No	Yes		No	Yes	
☐	☐	**Applicant appears to be providing unreliable or false information, specify in remarks**	☐	☐	**Obstetrics** Pregnancy, current Estimated delivery date *(mm-dd-yyyy)* _____ LMP _____
		General			
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*	☐	☐	Previous live births, number: _____ Birth dates of live births (mm-dd-yyyy) _____ _____
		Cardiology			
☐	☐	Hypertension			
☐	☐	Congestive heart failure or coronary artery disease			
☐	☐	Arrhythmia			
☐	☐	Rheumatic heart disease			
☐	☐	Congenital heart disease			**Sexually Transmitted Diseases** **Previous treatment for sexually transmitted diseases, specify date *(mm-yyyy)* and treatment:**
		Pulmonology	☐	☐	Syphilis _____
☐	☐	Tobacco use: ☐ Current ☐ Former	☐	☐	Gonorrhea _____
☐	☐	Asthma			
☐	☐	Chronic obstructive pulmonary disease			
☐	☐	Tuberculosis history: Diagnosed *(mm-yyyy)* _____ Treatment Completed *(mm-yyyy)* _____			**Endocrinology**
			☐	☐	Diabetes
			☐	☐	Thyroid disease
☐	☐	Fever			
☐	☐	Cough			**Hematologic/Lymphatic**
☐	☐	Night sweats	☐	☐	Anemia
☐	☐	Weight loss	☐	☐	Sickle Cell Disease
			☐	☐	Thalassemia
		Psychiatry	☐	☐	Other hemoglobinopathy
☐	☐	Psychological/Psychiatric Disorder (including major depression, bipolar disorder, or schizophrenia)			
					Other
☐	☐	Major impairment in learning, intelligence, self-care, memory, or communication	☐	☐	An abnormal or reactive HIV blood test Diagnosed (*mm-yyyy*) _____
☐	☐	Use of substances other than those required for medical reasons	☐	☐	Malignancy, specify: _____
☐	☐	Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)	☐	☐	Kidney or Bladder disease
			☐	☐	Chronic liver disease *(including hepatitis B or C)*
☐	☐	Substance use or substance induced disorders of substances not on the CSA (including alcohol)	☐	☐	Previous treatment for Hansen's Disease Treatment Completed *(mm-yyyy)* _____
☐	☐	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	☐	☐	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			

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

_____
_____
_____
_____

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

_____
_____
_____
_____

4. Vital Signs and Vision

Height _____ cm

Weight _____ kg

BMI _____ kg/m²

BP _____ / _____

Pulse _____ / min

Temperature _____ °C

Respiratory Rate _____ / min

Visual acuity at 6 meters:

Uncorrected L 6/ _____ R 6/ _____

Corrected L 6/ _____ R 6/ _____

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

N, normal; A, abnormal

N	A		N	A	
☐	☐	General appearance	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	Nutritional status *(including acute wasting and or chronic stunting malnutrition)*	☐	☐	Extremities *(including pulses, edema)*
			☐	☐	Skin
☐	☐	Hearing and ears	☐	☐	Hematologic
☐	☐	Eyes	☐	☐	Nervous system: Sequelae of stroke or cerebral palsy, other neurologic disabilities
☐	☐	Nose, mouth, and throat *(include dental)*			
☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*
☐	☐	Lungs			
☐	☐	Abdomen *(including liver, spleen)*			
☐	☐	Lymph nodes			Fundal height (if applicable): _____

6. Mental Health Specialist

☐ Referral made to mental health specialist. If so, attach report.

☐ Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder) ☐ Class A, with harmful behavior, list disorder(s) _____ ☐ Class B, without harmful behavior, list disorder(s) _____

☐ Addiction or abuse of a specific substance on the Controlled Substances Act

☐ Class A, list substance(s) _____ ☐ Class B, in remission, list substance(s) _____

7. Syphilis Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date specimen reported *(mm-dd-yyyy)*	Reactive	Non-reactive	Titer
Screening					
Confirmatory					

Treated

☐ Yes

☐ No

If treated, therapy:

☐ Benzathine penicillin, 2.4 MU IM

☐ Other *(therapy, dose)*: _____

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

_____ _____ _____

Treated by panel physician: ☐ Yes ☐ No

Stage of syphilis *(mark one):*

☐ Primary ☐ Tertiary

☐ Secondary ☐ Neurosyphilis

☐ Early latent ☐ Congenital

☐ Late latent or latent of unknown duration

8. Gonorrhea Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date speciman reported *(mm-dd-yyyy)*	Positive	Negative
Screening				

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

9. Diagnosis and Treatment for Hansen's Disease

Complete this section only if the applicant was diagnosed by the panel physician or was on Hansen's Disease treatment at the time of presentation for their medical examination

Type of Hansen's Disease

- ☐ Multibacillary
- ☐ Paucibacillary

Treatment

- ☐ Partial (≥ 7 days)
- ☐ 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 AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 15 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

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