



# MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

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	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Applicant appears to be providing unreliable or false information, specify in remarks</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Obstetrics</b>
		<b>General</b>			Pregnancy, current
<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	Estimated delivery date (mm-dd-yyyy) _____
		<b>Cardiology</b>			LMP _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Previous live births, number: _____
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure or coronary artery disease			Birth dates of live births (mm-dd-yyyy)
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia			_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease			_____
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease			<b>Sexually Transmitted Diseases</b>
		<b>Pulmonology</b>			<b>Previous treatment for sexually transmitted diseases, specify date (mm-yyyy) and treatment:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use: <input type="checkbox"/> Current <input type="checkbox"/> Former	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease			<b>Endocrinology</b>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis history: Diagnosed (mm-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
		Treatment Completed (mm-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Fever			<b>Hematologic/Lymphatic</b>
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia
		<b>Psychiatry</b>	<input type="checkbox"/>	<input type="checkbox"/>	Other hemoglobinopathy
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Psychiatric Disorder (including major depression, bipolar disorder, or schizophrenia)			<b>Other</b>
<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self-care, memory, or communication	<input type="checkbox"/>	<input type="checkbox"/>	An abnormal or reactive HIV blood test
<input type="checkbox"/>	<input type="checkbox"/>	Use of substances other than those required for medical reasons			Diagnosed (mm-yyyy) _____
<input type="checkbox"/>	<input type="checkbox"/>	Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)	<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Substance use or substance induced disorders of substances not on the CSA (including alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder disease
<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver disease (including hepatitis B or C)
<input type="checkbox"/>	<input type="checkbox"/>	Ever had thoughts of harming yourself	<input type="checkbox"/>	<input type="checkbox"/>	Previous treatment for Hansen's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts			Treatment Completed (mm-yyyy) _____
<input type="checkbox"/>	<input type="checkbox"/>	Ever had thoughts of harming others	<input type="checkbox"/>	<input type="checkbox"/>	Other medical conditions requiring treatment, specify:
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts			_____
		<b>Neurology</b>	<input type="checkbox"/>	<input type="checkbox"/>	Disabilities (including loss of arms or legs), specify:
<input type="checkbox"/>	<input type="checkbox"/>	History of stroke			_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder			_____

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>4. Vital Signs and Vision</b>			
Height _____ cm	BP _____ / _____	Temperature _____ °C	Visual acuity at 6 meters:
Weight _____ kg	Pulse _____ / min	Respiratory Rate _____ / min	Uncorrected L 6/ _____ R 6/ _____
BMI _____ kg/m <sup>2</sup>			Corrected L 6/ _____ R 6/ _____

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

**N, normal; A, abnormal**

N	A		N	A	
<input type="checkbox"/>	<input type="checkbox"/>	General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional status (including acute wasting and or chronic stunting malnutrition)	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic
<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system: Sequelae of stroke or cerebral palsy, other neurologic disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
<input type="checkbox"/>	<input type="checkbox"/>	Lungs			
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)			
<input type="checkbox"/>	<input type="checkbox"/>	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
<b>Screening</b>					
<b>Confirmatory</b>					
Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	If treated, therapy: <input type="checkbox"/> Benzathine penicillin, 2.4 MU IM <input type="checkbox"/> Other (therapy, dose): _____		Date(s) treatment given (mm-dd-yyyy)  _____		
Treated by panel physician: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Stage of syphilis (mark one): <input type="checkbox"/> Primary <input type="checkbox"/> Tertiary <input type="checkbox"/> Secondary <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Early latent <input type="checkbox"/> Congenital <input type="checkbox"/> Late latent or latent of unknown duration					

**8. Gonorrhea Laboratory Results and Treatment**

Laboratory testing not done

	Test Name	Date specimen reported (mm-dd-yyyy)	Positive	Negative
<b>Screening</b>				
<b>Drug</b>	<b>Dosage</b>	<b>Start Date (mm-dd-yyyy)</b>	<b>End Date (mm-dd-yyyy)</b>	

**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      Treatment
- Multibacillary                       Partial (≥ 7 days)
- Paucibacillary                       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**

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**PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS**

**PAPERWORK REDUCTION ACT STATEMENT**

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