



MEDICAL HISTORY AND EXAMINATION FOR INDIVIDUALS AGE 12 AND OLDER

PRIVACY ACT NOTICE

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 from this form will assist in making a medical clearance decision for individuals eligible to participate in the Department of State Medical Program while assigned abroad. (16 FAM 100 - 200)
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 TO BE FILLED OUT BY EXAMINEE (OR PARENT)	DATE OF EXAM (mm-dd-yyyy)
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1. Name of Examinee (Last, First, MI)	2. If Eligible Family Member, Name of Employee/Applicant
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3. Date of Birth (mm-dd-yyyy)	4. MED ID (if available)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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6. Place of Birth City _____ State _____ Country _____	7. Status <input type="checkbox"/> Applicant <input type="checkbox"/> Employee <input type="checkbox"/> New Family Member (Spouse, Newborn, Adoption) <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse
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8. Agency of Employee/Applicant/Sponsor
 STATE USAID FCS FAS U.S. Agency for Global Media DoD Civilian DoD Contractor
 Non-Foreign Service Agency _____ Contracting Company _____

9. Health Insurance Plan	10. Purpose of Exam <input type="checkbox"/> Pre-Employment Exam <input type="checkbox"/> In-Service Exam <input type="checkbox"/> Separation Exam <input type="checkbox"/> REA-WAE	11. Employment Status <input type="checkbox"/> Civil Service <input type="checkbox"/> LES <input type="checkbox"/> Contractor <input type="checkbox"/> LNA <input type="checkbox"/> PSC Contractor <input type="checkbox"/> Fellow <input type="checkbox"/> FS Officer <input type="checkbox"/> Other <input type="checkbox"/> FS Specialist
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12. E-mail Address of examinee or parent of child < 18 y/o (Where You can be Reached for the Next 90 days) Primary: _____ Alternate: _____	14. Employment Status <input type="checkbox"/> TDY (Regional hub or CONUS based) <input type="checkbox"/> Iraq - List Post _____ <input type="checkbox"/> Afghanistan <input type="checkbox"/> Other ESCAPE Post(s) If yes, list _____
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13. Telephone Number of examinee or parent of child < 18 y/o (Where You can be Reached for the Next 90 days) Primary: _____ Alternate: _____	15. Post of Assignment and Estimated Dates of Arrival / Departure a. Proposed Post _____ EDA _____ (mm-dd-yyyy) b. Present Post _____ EDD _____ (mm-dd-yyyy)
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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.

Name of Examinee	DOB
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II. MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS: ALL YES ANSWERS MUST HAVE A WRITTEN EXPLANATION WITH DATE OF OCCURENCE IN BOX IIA.

<p>Do you (or your child) have a hisory of: (parents - please answer for children < 18 years of age)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> 1. Frequent/severe headaches or migraines?</p> <p><input type="checkbox"/> <input type="checkbox"/> 2. Fainting, dizzy episodes, or syncope?</p> <p><input type="checkbox"/> <input type="checkbox"/> 3. Stroke, TIA or head injury?</p> <p><input type="checkbox"/> <input type="checkbox"/> 4. Epilepsy, seizures or other neurologic disorders?</p> <p><input type="checkbox"/> <input type="checkbox"/> 5. Eye or vision problems?</p> <p><input type="checkbox"/> <input type="checkbox"/> 6. Ear, nose, throat problems; hearing loss, hoarseness?</p> <p><input type="checkbox"/> <input type="checkbox"/> 7. Allergies or history of anaphylactic reaction?</p> <p><input type="checkbox"/> <input type="checkbox"/> 8. Shortness of breath, asthma, or COPD?</p> <p><input type="checkbox"/> <input type="checkbox"/> 9. History of abnormal chest x-ray?</p> <p><input type="checkbox"/> <input type="checkbox"/> 10. History of positive TB skin test, IGRA, or tuberculosis?</p> <p><input type="checkbox"/> <input type="checkbox"/> 11. Aneurysm, blood clot or pulmonary embolism?</p> <p><input type="checkbox"/> <input type="checkbox"/> 12. High blood pressure?</p> <p><input type="checkbox"/> <input type="checkbox"/> 13. Murmurs, palpitations, or other heart problems?</p> <p><input type="checkbox"/> <input type="checkbox"/> 14. Are you a former or current smoker?</p> <p><input type="checkbox"/> <input type="checkbox"/> 15. Stomach, esophageal, or other intestinal problems?</p> <p><input type="checkbox"/> <input type="checkbox"/> 16. Jaundice, hepatitis, or other liver disease?</p> <p><input type="checkbox"/> <input type="checkbox"/> 17. Intestinal, rectal problems or hernia?</p> <p><input type="checkbox"/> <input type="checkbox"/> 18. Urinary or kidney problems, blood in urine?</p> <p><input type="checkbox"/> <input type="checkbox"/> 19. Diabetes, thyroid, or other endocrine disorders?</p> <p><input type="checkbox"/> <input type="checkbox"/> 20. Joint or back pain/injury?</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 style="width:80%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>21. Rheumatologic disorder?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>22. Anemia?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>23. Blood transfusion?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>24. Malaria, tropical or other infectious disease?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>25. Any skin or nail disorder?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>26. Cancer of any type?</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>27. Any thickening or lump in breast, testicle?</td> </tr> </table> <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 style="width:80%;"></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>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.</td> </tr> </table> <p>IN THE PAST SEVEN (7) YEARS (for questions 29-33) (parents - please answer for children < 18 years of age)</p> <p><input type="checkbox"/> <input type="checkbox"/> 29. Have you used marijuana, amphetamines, narcotics, cocaine, or hallucinogenic drugs?</p> <p><input type="checkbox"/> <input type="checkbox"/> 30. Have you been in psychotherapy/counseling or been prescribed medication for depression, anxiety, mood or stress?</p> <p><input type="checkbox"/> <input type="checkbox"/> 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"/> <input type="checkbox"/> 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"/> <input type="checkbox"/> 33. Have you experienced any emotional or physical symptoms related to a past trauma?</p>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	21. Rheumatologic disorder?	<input type="checkbox"/>	<input type="checkbox"/>	22. Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	23. Blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	24. Malaria, tropical or other infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	25. Any skin or nail disorder?	<input type="checkbox"/>	<input type="checkbox"/>	26. Cancer of any type?	<input type="checkbox"/>	<input type="checkbox"/>	27. Any thickening or lump in breast, testicle?	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	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.
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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>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>37. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Est. due date: _____</p>	<p>Colon Cancer Screening: (<i>Submit results</i>)</p> <p>38. History of abnormal colon cancer screening? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Date _____</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

IIA. Explanations required for "Yes" answers to questions 1-39. Attach additional sheets as needed.

III. LIST OF CURRENT MEDICATIONS (<i>Prescription, over the counter, and vitamins/supplements with dosage and frequency</i>)	Drug Or Other Allergies

IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS (<i>Include all medical and psychiatric illnesses</i>)			
Date (<i>mm-dd-yyyy</i>)	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.

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

Name of Examinee	DOB
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VI. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF FORM DS-1843

NOTICE: This history and physical are used to make a medical clearance decision based on an individual's anticipated medical requirements while living or traveling abroad. This exam does not meet the requirements of an age appropriate wellness exam.

- MEDICAL EXAMINER**
- Medical Examiner must comment on positive history (pg. 2), abnormal physical findings (pg. 3), and provide follow-up recommendations (pg. 4).
 - 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-1843.
 - 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).

Submit the DS-1843 and other documentation via email in PDF format to MEDMR@state.gov (preferred), or by fax to the Medical Records Department at 202-647-0292. If you wish to confirm that your exam forms were received, email MEDMR@state.gov.

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

(This area is intentionally left blank for medical examiner comments.)

VIII: Clinical Evaluation

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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IX. Clinical Evaluation Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	Notes <i>(Describe every abnormality in detail. Include pertinent item number before each comment.)</i>
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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>)				

Name of Examinee	DOB
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IX. LABORATORY ANALYSIS COPIES OF LABORATORY REPORTS MUST BE ATTACHED

- 1. Required Labs (Must attach)**
- A. Hematology** (must include: Hematocrit, Hemoglobin, White Blood Cell Count, and Platelets)
 - B. Chemistry** (must include: Fasting Blood Sugar, Creatinine, and ALT. Hemoglobin A1c if indicated)
 - C. Serology** (must include: HEP B Surface Antigen, HEP C Antibody, RPR/VDRL, and HIV I/II Antibody)
 - D. Lipid Profile** (only if > 50 years of age: Total Cholesterol, LDL, HDL, and Triglycerides)

ALL TESTS ARE REQUIRED UNLESS OTHERWISE SPECIFIED. TEST RESULTS FROM PREVIOUS 12 MONTHS ARE ACCEPTABLE. LABORATORY REPORTS MUST BE IN ENGLISH. ATTACH LABS TO THIS FORM.

<p>2. Tuberculin Skin Test : <u>REQUIRED</u> <i>(unless previously positive)</i> For baseline status as individual who will live overseas in an endemic TB area.</p> <p>TST Results: _____ mm of induration Date: _____</p> <p style="text-align: center;">OR</p> <p>IGRA Results: _____ Date: _____</p> <p><i>Interferon Gamma Release Array: (may substitute for TST if > 5 y/o or In those with previous BCG)</i></p> <p>Previous active tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p>Previous positive TST or IGRA <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p>Previous LTBI treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p> <p>Hx of BcG vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____</p>	<p>3. Chest X Ray (PA and lateral) - Required only if TST > 10mm, positive IGRA or clinically indicated.</p> <p>Results: _____</p> <p>Date: _____</p> <hr/> <p>4. ECG (50 years or older, earlier if indicated) - SUBMIT TRACING</p> <p>Results: _____</p> <p>Date: _____</p>
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OPTIONAL TESTS: The following tests are not required for a medical clearance determination. The expense of performing these exams is not routinely authorized. The tests may be performed at the clinical discretion of the examiner with patient consent. If performed or previous results are available, the results may be used by the Department of State in a medical clearance determination and future clinical care of individuals covered under the Department's Medical Program.

5. Blood Type (if not previously documented) Type: ABO _____ (Rh) Dμ: _____ (weak D): _____
6. G6PD (If not previously documented) for malarial prophylaxis Results: _____ Date: _____
7. PAP/Cervical Cytology Results: _____ Date: _____
8. Mammogram Results: _____ Date: _____
9. Colon Cancer Screen Test (colonoscopy/sigmoidoscopy/guiau FOBT/other): _____ Results: _____ Date: _____

X. Assessment or Problem List	XI. Recommendation for Treatment / Further Study / Consultation or Follow - Up

NOTICE: This form is not complete until all laboratory tests and results from section IX are attached and included with this DS-1843 form.

Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
Address	Telephone Number	