

Pre exam: Health case details

Panel Physician Report on Medical Examination and Vaccination Record

OMB Control Number <OMB Control number>
 Form Number DS-7794
 Expiration Date 09/30/2020
 Estimated Burden 60 minutes

Client personal details

Surnames <Family name>
 Given names <Given name(s)>
 Sex <Gender>
 Birth date <Dd Mmm yyyy>
 Birthplace (Country) <Country (DEPT)>
 Birthplace (City) *
 Prior Country of Residence *
 Country of Nationality *

Client identity details

Document type Original Passport
 Document Number <number>
 Issuing Country <country (ICAO)>
 Date of issue <Dd Mmm yyyy>
 Date of expiry <Dd Mmm yyyy>
 Source

Other Identifiers

Identifier type	Identifier value
Case ID	456789456
CEAC barcode	8978335

Client visa details

Applicant Category NIV - Non-Immigrant Visa

Client declaration

* I declare that NAME (or their parent/guardian) has read and understands the information provided by the U.S. Department of State regarding eMedical and has agreed to his/her medical information being submitted electronically to the Department, with this consent to be recorded by this clinic in eMedical.

<User name>

<Today's date (dd Mmm yyyy)>

Name of parent/guardian

Relationship to the client

[View client declaration](#)

Contact Channels

Delete	Contact Channel	Contact details	Primary	Comments	Edit
	eMail (Personal)	applicant@gmail.com	Yes	-	
	Address (Home)	Somewhere, Else, ACT, AUSTRALIA	Yes	-	
	Address (Intended)	298 West 33rd Street, New York, NY 10001, USA	No	-	

Paperwork Reduction Act statement

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501 Medical Examination: Past medical history

Answer 'No' to all

Record Medical History (Past or present)

General

Illness or injury requiring hospitalization (including psychiatric)

Not selected No Yes

Cardiology

Hypertension

Not selected No Yes

Congestive heart failure or coronary artery disease

Not selected No Yes

Arrhythmia

Not selected No Yes

Rheumatic heart disease

Not selected No Yes

Congenital heart disease

Not selected No Yes

Pulmonology

Current Tobacco use

Not selected No Yes

Former Tobacco use

Not selected No Yes

Asthma

Not selected No Yes

Chronic obstructive pulmonary disease

Not selected No Yes

History of Tuberculosis

Not selected No Yes

Diagnosed (mm-yyyy) Treatment Treatment completed (mm-yyyy)

- Select an option -

Add

Not selected No Yes

Anatomic site of disease

Treatment

Not selected No Current Started but not finished Completed

Fever

Not selected No Yes

Cough

Not selected No Yes

Night sweats

Not selected No Yes

Weight loss

Not selected No Yes

Signs or symptoms of TB

Not selected No Yes

Recent contact with known TB case

Not selected No Yes

Contact's Name

Contact's case or Alien number, if known

Applicant's relationship to Contact

Select an Option

Provide details

Date contact ended

20Jun2015

Type of source case TB

Select an Option

Psychiatry

Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia)

Not selected No Yes

Major impairment in learning, intelligence, self-care, memory or communication

Not selected No Yes

Use of substances other than those required for medical reasons

Not selected No Yes

Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)

Not selected No Yes

Referral made to mental health specialist

Not selected No Yes

Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act, but including other substance-related disorder)

Not selected No Yes

Class A, with harmful behaviour

Not selected No Yes

List disorder(s)

Class B, without harmful behaviour

Not selected No Yes

List disorder(s)

Addiction or abuse of specific substance on the Controlled Substances Act

Not selected No Yes

Class A

Not selected No Yes

List substance(s)

Class B, in remission

Not selected No Yes

List substance(s)

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501 Medical Examination: Past medical history

Substance use or substance induced disorders of substances not on the CSA (including alcohol)
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
Ever had thoughts of harming yourself
Ever acted on those thoughts
Ever had thoughts of harming others
Ever acted on those thoughts

Neurology

History of stroke
Seizure disorder

Obstetrics

Pregnant, on the day of exam?
Estimated Delivery Date
LMP
Fundal Height (in cm)
Normal / Abnormal

Previous live births:

Birth dates:

Sexually Transmitted Diseases

Syphilis

Previous treatment for Syphilis

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Gonorrhea

Previous treatment for Gonorrhea

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Endocrinology

Diabetes
Thyroid disease

Hematologic/Lymphatic

Anemia
Sickle Cell Disease
Thalassemia
Other hemoglobinopathy

Hansen's Disease

Hansen's Disease history

Diagnosed (mm yyyy)
Treatment completed (mm yyyy)

Initial Diagnosis
Test name
Date result reported
Test Result
Made by
Year of diagnosis
Type of Hansen's disease
Treatment
Treated by panel physician?
Referred for treatment?
Referral facility

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Other

An abnormal or reactive HIV blood test

Diagnosed (mm-yyyy)

Malignancy

Specify

Kidney or Bladder disease

Chronic liver disease (Including hepatitis B or C)

Food or drug allergies

Specify

Other medical conditions requiring treatment

Specify

Disabilities (including loss of arms or legs)

Specify

Current medications (List all current medications)

Specify

Previous surgeries (List all previous surgeries)

Specify

Doctor declaration

Applicant appears to be providing unreliable or false information

Specify

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501 Medical Examination: Basic questions

Basic Questions

Exam date

Height and Weight

Height

In centimeters

Weight

In kilograms

BMI

Blood Pressure

Initial blood pressure

Systolic

Diastolic

Pulse

Vital signs

Temperature

In °C

Respiratory rate

/ min

Eyes

Visual acuity testing Not selected Uncorrected Corrected No (applicant under 4)

Left eye:

Right eye:

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501 Medical Examination: Detailed questions

Answer 'Normal' to all

All systems

General appearance

* Not selected Normal Abnormal

Nutritional status (including acute wasting and or chronic stunting malnutrition)

* Not selected Normal Abnormal

Heart (S1, S2, murmur, rub)

* Not selected Normal Abnormal

Provide details

*

Lungs (auscultation)

* Not selected Normal Abnormal

Nervous system: Sequelae of stroke or cerebral palsy, other neurological disabilities

* Not selected Normal Abnormal

Abdomen (including liver, spleen)

* Not selected Normal Abnormal

Musculoskeletal system (including gait)

* Not selected Normal Abnormal

Extremities (including pulses, edema)

* Not selected Normal Abnormal

Hematologic

* Not selected Normal Abnormal

Brain and cognition

Mental status (including mood, intelligence, perception, thought processes, and behaviour during examination)

* Not selected Normal Abnormal

Eyes, ears, nose, throat and mouth

Eyes

* Not selected Normal Abnormal

Nose, mouth and throat (include dental)

* Not selected Normal Abnormal

Hearing and ears

* Not selected Normal Abnormal

Miscellaneous

Exposed Skin

* Not selected Normal Abnormal

Lymph nodes

* Not selected Normal Abnormal

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Provide Classification

Please complete the 501 Medical Examination. If you have completed the exam and you are ready to provide the Classification, press the 'Prepare for Classification' button

Prepare for classification

Classification

Class A Conditions

- Tuberculosis disease (1A1)
- Syphilis, untreated (1A1)
- Gonorrhea, untreated (1A1)
- Hansen's Disease, untreated multibacillary or paucibacillary (1A1)
- Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder) with harmful behavior or history of such behavior likely to recur (1A3)
- Addiction or abuse of specific substance on the Controlled Substances Act (1A4)
- Immigrant visa applicant refuses vaccinations (1A2)

Class B Conditions

Tuberculosis

- B0 TB, Pulmonary
- B1 TB, Pulmonary
- B1 TB, Extrapulmonary

Anatomic site of disease *
Treatment * Not selected No Current Started but not finished Completed

B2 TB: LTBI evaluation

LTBI treatment * Not selected No Current Started but did not finish Completed
Treated by Panel Physician * Not selected No Yes
LTBI regimen *
Details *
Treatment started *
Treatment ended

B3 TB: Contact Evaluation

Preventative treatment * Not selected No Window prophylaxis
Prophylaxis Regime *
Details *
Treatment started *
Treatment ended

- Syphilis, treated within last year
- Gonorrhea, treated within last year

Hansen's Disease

- Treated multibacillary
- Treated paucibacillary

- Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur
- Sustained, full remission of addiction or abuse of specific substance on the Controlled Substances Act

Class B Other

Details *

No apparent defect, disease or disability

Remarks

General supporting comments

If you wish to update the examination answers then press the 'Edit exam' button.

Edit exam

Examiner declaration

I attest that I performed this examination, have reviewed all test results, and that the medical classification is correct in accordance with the Centers for Disease Control and Prevention's Technical Instructions for panel physicians.
I further attest that I have a current panel physician agreement with the Department of State.

Completed by <Doctor's name>
Date of declaration <Today's date>

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Classification

Class A Conditions

- Tuberculosis disease (1A1)
- Syphilis, untreated (1A1)
- Gonorrhea, untreated (1A1)
- Hansen's Disease, untreated multibacillary or paucibacillary (1A1)
- Any physical or mental disorder (*excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder*) with harmful behavior or history of such behavior likely to recur (1A3)
- Addiction or abuse of specific substance on the Controlled Substances Act (1A4)
- Immigrant visa applicant refuses vaccinations (1A2)

Class B Conditions

~~Tuberculosis~~

B0 TB, Pulmonary

B1 TB, Pulmonary

B1 TB, Extrapulmonary

B2 TB: LTBI evaluation

B3 TB: Contact Evaluation

Syphilis, treated within last year

Gonorrhea, treated within last year

Hansen's Disease

Treated multibacillary

Treated paucibacillary

Any physical or mental disorder (*excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder*) without harmful behavior or history of such behavior unlikely to recur

Sustained, full remission of addiction or abuse of specific substance on the Controlled Substances Act

Class B Other

No apparent defect, disease or disability

Remarks

General supporting comments

If you wish to update the examination answers then press the 'Edit exam' button.

Edit exam

Examiner declaration

I attest that I performed this examination, have reviewed all test results, and that the medical classification is correct in accordance with the Centers for Disease Control and Prevention's Technical Instructions for panel physicians.

I further attest that I have a current panel physician agreement with the Department of State.

Completed by <Doctor's name>

Date of declaration <Today's date>

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502 Chest X-ray Examination: Pregnancy Declaration

Pregnancy, current

Not selected No Yes

Estimated delivery date (mm-dd-yyyy)

25Jun2012 

Does the client wish to proceed with the required X-ray examination(s)?

Not selected No Yes

Pre exam

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502 Chest X-ray Examination: Attach x-ray images

Attach x-ray images

Date of x-ray

*



Attachments

[Link to existing](#)



[Add new](#)



Delete	Document type	Details	Attachment type	Sending method	File name	Edit
No documents have been attached						

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502 Chest X-ray Examination: Findings

Record results

Exam date

* 

Findings

* Not selected Normal Abnormal

Mark all that apply

Suggests Tuberculosis (*will require Smears and Cultures*)

- | | | |
|---|---|---|
| <input type="checkbox"/> Infiltrate or consolidation | <input type="checkbox"/> Pleural effusion | <input type="checkbox"/> Discrete nodule(s) without calcification |
| <input type="checkbox"/> Reticular markings suggestive of fibrosis | <input type="checkbox"/> Hilar / mediastinal adenopathy | <input type="checkbox"/> Volume loss or retraction |
| <input type="checkbox"/> Cavitory lesion | <input type="checkbox"/> Miliary findings | <input type="checkbox"/> Irregular thick pleural reaction |
| <input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculoma) | <input type="checkbox"/> Discrete linear opacity | <input type="checkbox"/> Other |

Smears and Cultures not required

- | | |
|--|---|
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Smooth pleural thickening (if at CPA, must confirm is not effusion [do lateral or decubitus radiograph or ultrasound]) |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Diaphragmatic tenting |
| <input type="checkbox"/> Other | <input type="checkbox"/> Single or scattered calcified pulmonary nodule(s) |
| | <input type="checkbox"/> Calcified lymph node(s) |

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502 Chest X-ray Examination: Examiner Declaration

Prepare for Declaration

<variable text according to exam status>

General supporting comments

Prepare for Declaration

Edit Exam

If you wish to update the examination answers then press the 'Edit exam' button

Examiner declaration

I declare that this chest x-ray examination report is a true and correct record of my findings

Completed by

<Radiologist's name>

Date of declaration

<Today's date>

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603 Respiratory Specialist investigation on current state of tuberculos: Record results

Record results

Exam date *

Exam description * Investigation required to determine the current status regarding tuberculosis. Please include the following information:
 -Results of 3 current smears and cultures (sputum samples taken on 3 consecutive working mornings, or other appropriate specimens as clinically indicated) and cultures for Mycobacterium tuberculosis (plus drug susceptibility testing (DST) if cultures are positive),
 -Old chest x-rays for comparison (if available). Reports can be submitted if images available are not digital,
 -Any previous reports regarding any treatment of tuberculosis.

Sputum Smears and Cultures

Sputum Smear Laboratory *

Sputum Culture Laboratory *

Specimen obtained	Test date	Test name	Result	Remarks
<dd Mmm yyyy>	<dd Mmm yyyy>	Sputum Smear	Positive	-
<dd Mmm yyyy>	<dd Mmm yyyy>	Culture	Negative	Path lab closed

Recording of Laboratory Tests is complete

Clinical diagnosis of TB? * Not selected Yes No

Drug susceptibility tests

Method of DST *

Date specimen obtained *

Date specimen reported *

Drug Susceptibility Test Laboratory *

Drug	Finding
Isoniazid	<Susceptible / Resistant>

Molecular tests * Not selected Yes No

Molecular Test	Mycobacterium Tuberculosis	Rifampin resistance	Isoniazid resistance
Hain Line Probe Assay	<Positive / Negative / Not tested>	<Positive / Negative / Not tested>	<Positive / Negative / Not tested>
GeneXpert	<Positive / Negative / Not teted>	<Positive / Negative / Not tested>	<Positive / Negative / Not tested>

Attachments

General Supporting Comments

Add / Edit Molecular test + X

Molecular test * ▼

Other *

Mycobacterium Tuberculosis * Not selected Positive Negative Not tested

Rifampin Resistance * Not selected Positive Negative Not tested

Isoniazid Resistance * Not selected Positive Negative Not tested

607 Continued tuberculosis treatment: Record results

Record results

Exam date

Exam Description Positive sputum smears/cultures or commencement of TB treatment advice noted with thanks. Await final report with repeat chest x-ray upon completion of TB treatment.

Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Treated at approved DOT site? Not selected No Yes
 Recording of Treatment is complete

Post-treatment Clinical diagnosis (for Radiologist to complete)

Date radiograph obtained 20Jun2017

Findings suggestive of TB? Not selected No Yes

Findings present

Suggests Tuberculosis

Infiltrate or consolidation Pleural effusion Discrete nodule(s) without calcification
 Reticular markings suggestive of fibrosis Hilar / mediastinal adenopathy Volume loss or retraction
 Cavitary lesion Miliary findings Irregular thick pleural reaction
 Nodule(s) or mass with poorly defined margins (such as tuberculoma) Discrete linear opacity Other

Does not suggest Tuberculosis

Cardiac Smooth pleural thickening (if at CPA, must confirm is not effusion [do lateral or decubitus radiograph or ultrasound])
 Musculoskeletal Diaphragmatic tenting
 Other Single or scattered calcified pulmonary nodule(s)
 Calcified lymph node(s)

Remarks

Interpreted by <Radiologist's name>

Date radiograph interpreted 23Jun2017

I declare that these are a true and correct record of my findings

Sputum Smears and Cultures

Sputum Smear Laboratory <List of associated Pathology clinics>

Sputum Culture Laboratory <List of associated Pathology clinics>

Date Specimen obtained	Specimen Report date	Test name	Result	Remarks
<dd Mmm yyyy>	<dd Mmm yyyy>	Sputum Smear	Positive	-
<dd Mmm yyyy>	<dd Mmm yyyy>	Culture	Negative	Path lab closed

Recording of Laboratory Tests is complete

Clinical diagnosis of TB? Not selected Yes No

Drug susceptibility tests

Method of DST Select an option

Date specimen obtained

Date specimen reported

Drug Susceptibility Test Laboratory <List of associated Pathology clinics>

Required for first-line DST

Isoniazid Not selected Susceptible Resistant

Rifampin Not selected Susceptible Resistant

Ethambutol Not selected Susceptible Resistant

Pyrazinamide Not selected Susceptible Resistant

Required for multidrug-resistant cases

Ethionamide Not selected Susceptible Resistant

Capreomycin Not selected Susceptible Resistant

Amikacin Not selected Susceptible Resistant

Para-aminosalicylic acid (PAS) Not selected Susceptible Resistant

Fluoroquinolone Not selected Susceptible Resistant

Specify

Susceptibility to other drugs

Other drug 1	<input type="text"/>
Finding 1	<input checked="" type="radio"/> Not selected <input type="radio"/> Susceptible <input type="radio"/> Resistant
Other drug 2	<input type="text"/>
Finding 2	<input checked="" type="radio"/> Not selected <input type="radio"/> Susceptible <input type="radio"/> Resistant
Other drug 3	<input type="text"/>
Finding 3	<input checked="" type="radio"/> Not selected <input type="radio"/> Susceptible <input type="radio"/> Resistant
Other drug 4	<input type="text"/>
Finding 4	<input checked="" type="radio"/> Not selected <input type="radio"/> Susceptible <input type="radio"/> Resistant
Other drug 5	<input type="text"/>
Finding 5	<input checked="" type="radio"/> Not selected <input type="radio"/> Susceptible <input type="radio"/> Resistant

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712 Syphilis test (VDRL or RPR): Record results

Record results

Exam date * 

Exam description Syphilis testing and results are required

Screening

Test name *


Date specimen reported * 

Syphilis test result * Not selected Non-reactive Reactive


Titer * 

Confirmatory


Test name *

Date specimen reported * 

Repeat Syphilis test result * Not selected Non-reactive Reactive



Repeat Titer * 

Clinical judgment on result * Not selected Treatment warranted Previous treatment, no new risk factors since treatment

Stage of Syphilis * 

Applicant elects to undergo treatment? * Not selected No Yes

Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	 

By Panel Physician? * Not selected No Yes

Recording of Treatment is complete

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713 Gonorrhoea: Record results

Record results

Exam Date *

Exam description Record testing and treatment for Gonorrhoea

Was laboratory testing performed * Not selected No Yes

Screening

Date specimen reported *

Test name *

Gonorrhoea test result * Not selected Positive Negative

Applicant elects to undergo treatment? * Not selected No Yes

Treatment

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	

Recording of Treatment is complete

Attachments

General Supporting Comments

714 Hansen's Disease: Record results

Record results



Exam Date * 20Jun2015

Exam description Record diagnosis and treatment for Hansen's Disease

Initial Diagnosis

Test name * [Text Input]

Date result reported * 20Jun2015

Test Result * Not selected Positive Negative

Made by * Not selected Panel Physician Non-panel physician prior to current evaluation

Year of diagnosis * 2005

Type of Hansen's disease * Not selected Multibacillary Paucibacillary

Treatment

Treatment * Not selected None Partial (≥7 days) Completed

Treated by panel physician? * Not selected No Yes

Referred for treatment? * Not selected No Yes

Referral facility * [Text Input]

Treatment	Medication	Start	End	Dose	Frequency	Side effects
<Treatment>	<Drug>	dd Mmm yyyy	dd Mmm yyyy	10mg	1x3/day	




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719 TB screening test - TST or IGRA: Record results

Record results


Exam Date (date drawn/applied) * 20Jun2015 

Exam description Provide current results of tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).

Type of exam conducted * Not selected Tuberculin Skin Test (TST) Interferon Gamma Release Assay (IGRA)

Date of Reading * 27Jun2015 

Millimetres of induration *

Type of IGRA test * Select an Option 

Result * Not selected Negative Indeterminate, Borderline or Equivocal Positive

QuantiFERON (optimal density value [IU/ml] for each)

Nil *

TB antigen 1 *

TB antigen 2 *

Mitogen *

T-Spot (Spot count for each)

Nil Control *

Panel A *

Panel B *

General supporting comments

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Delete	Document type	Details	Attachment type	Sending method	File name	Edit
No documents have been attached						

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951 Vaccination: Record results

Record results

Exam date * 

Exam Description Applicant's full vaccination history is required



Disease	Vaccine	Vaccination history	Administered by clinic	Immunity Positive	History	Waiver reasons
<Disease name>	<Vaccine name>	dd Mmm yyyy dd Mmm yyyy dd Mmm yyyy dd Mmm yyyy	dd Mmm yyyy dd Mmm yyyy dd Mmm yyyy	dd Mmm yyyy	Yes	Contra-indicated Flu Vaccine not available  

Vaccination Documentation

Vaccination requirements complete? * Not selected No Yes ?

Reason

* Select an Option 

Refugee, follow to join Asylee/Refugee (V92/93) applicant not required to meet vaccination requirements

K-Visa applicant electing to not be vaccinated at this examination

Other NIV applicant not required to meet vaccination requirements

Immigrant Visa or Parolee applicant completed vaccination requirements

K Visa applicant voluntarily completed vaccination requirements


Contra-indications

- Current Pregnancy
- Immune compromised
- History of severe allergic reaction to vaccine or vaccine component
- Other severe reaction to vaccine
- Current moderate to severe illness
- Other

Other Contra-indication

*

Remarks

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106 Mental Health report: Record results

Record results

Exam date

Exam description

Mental health questions must be answered by panel physician. If applicant is referred to a mental health specialist for further evaluation, panel physician must 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) *

Not selected No Yes

Class A, with harmful behaviour *

Not selected No Yes

List disorder(s) *

Class B, without harmful behaviour *

Not selected No Yes

List disorder(s) *

Addiction or abuse of specific substance on the Controlled Substances Act *

Not selected No Yes

Current addiction or abuse?

Not selected No Yes

Details of substances *

Sustained, full remission? *

Not selected No Yes

Details of substances *

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