U.S. Department of State
Bureau of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION
FOR INDIVIDUALS AGE 12 AND OLDER

I. DEMOGRAPHIC INFORMATION
TO BE FILLED OUT BY EXAMINEE (OR PARENT)

DATE OF EXAM *(mm-dd-yyyy)*

1a. Name of Examinee *(Last, First, MI)*

1b. Chosen Name of Examinee

2. If Eligible Family Member, Name of Employee/Applicant

3. Date of Birth of Examinee *(mm-dd-yyyy)*

4. Place of Birth of Examinee
City _____ State _____ Country _____

5a. Gender Identity - Choose all that apply
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non-binary
- ☐ Another Gender _____

5b. Sex Assigned at Birth
- ☐ Male
- ☐ Female

5c. Gender Pronouns - Choose all that apply:
- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ _____

5d. Sexual Orientation
- ☐ Lesbian, Gay, Homosexual
- ☐ Straight, Heterosexual
- ☐ Bisexual
- ☐ I use a different term _____
- ☐ I don't know

6. Status
☐ Applicant ☐ Employee ☐ New Family Member (Spouse, Newborn, Adoption) ☐ Dependent Child ☐ Spouse

7. Agency of Employee/Applicant/Sponsor
☐ STATE ☐ USAID ☐ FCS ☐ FAS ☐ U.S. Agency for Global Media ☐ DoD Civilian ☐ DoD Contractor
☐ Other Government Agency _____ ☐ Contracting Company _____

8. Health Insurance Plan

9. Purpose of Exam
- ☐ Pre-Employment Exam
- ☐ In-Service Exam
- ☐ Separation Exam
- ☐ REA-WAE

10. Employment Status
- ☐ Civil Service
- ☐ FS Officer
- ☐ PSC Contractor
- ☐ 3rd Party Contractor
- ☐ CA-EFM
- ☐ LES
- ☐ LNA
- ☐ Fellow
- ☐ EPAP
- ☐ Other

11. E-mail Address of examinee or parent of child < 18 y/o
(Where You can be Reached for the Next 90 days)

Primary: _____

Alternate: _____

12. Telephone Number of examinee or parent of child < 18 y/o
(Where You can be Reached for the Next 90 days)

Primary: _____

Alternate: _____

13. Employment Status
- ☐ TDY (Regional hub or CONUS based)
- ☐ Iraq - List Post _____
- ☐ Other ESCAPE Post(s) If yes, list _____

14. Post of Assignment and Estimated Dates of Arrival / Departure

a. Proposed Post _____ EDA _____ *(mm-dd-yyyy)*

b. Present Post _____ EDD _____ *(mm-dd-yyyy)*

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

II. MEDICAL HISTORY

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

Do you (or your child) have a hisory of:
(parents - please answer for children < 18 years of age)

Yes	No	
☐	☐	1. Frequent/severe headaches or migraines?
☐	☐	2. Fainting, dizzy episodes, or syncope?
☐	☐	3. Stroke, TIA or head injury?
☐	☐	4. Epilepsy, seizures or other neurologic disorders?
☐	☐	5. Eye or vision problems?
☐	☐	6. Ear, nose, throat problems; hearing loss, hoarseness?
☐	☐	7. Allergies or history of anaphylactic reaction?
☐	☐	8. Shortness of breath, asthma, or COPD?
☐	☐	9. History of abnormal chest x-ray?
☐	☐	10. History of positive TB skin test, IGRA, or tuberculosis?
☐	☐	11. Aneurysm, blood clot or pulmonary embolism?
☐	☐	12. High blood pressure?
☐	☐	13. Murmurs, palpitations, or other heart problems?
☐	☐	14. Are you a former or current smoker?
☐	☐	15. Stomach, esophageal, or other intestinal problems?
☐	☐	16. Jaundice, hepatitis, or other liver disease?
☐	☐	17. Intestinal, rectal problems or hernia?
☐	☐	18. Urinary or kidney problems, blood in urine?
☐	☐	19. Diabetes, thyroid, or other endocrine disorders?
☐	☐	20. Joint or back pain/injury?
☐	☐	21. Are you pregnant?
☐	☐	22. Rheumatologic disorder?
☐	☐	23. Anemia?
☐	☐	24. Blood transfusion?

Yes	No	
☐	☐	25. Malaria, tropical or other infectious disease?
☐	☐	26. Any skin or nail disorder?
☐	☐	27. Cancer of any type?
☐	☐	28. Any thickening or lump in breast, testicle?

IN THE PAST SEVEN (7) YEARS (for questions 29-33)
(parents - please answer for children < 18 years of age)

Yes	No	
☐	☐	29. Has your child been referred or evaluated for any special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)?
☐	☐	30. Have you been in psychotherapy or counseling for the treatment of anxiety, depression/mood problems, psychological trauma, or any other mental health or behavioral health concerns?
☐	☐	31. Have you been prescribed medication for depression, anxiety, mood, or stress, memory/attention, or any other mental health or behavioral health symptoms?
☐	☐	32. Have you been diagnosed with an alcohol or drug-related problem, been medically advised to reduce use of a substance, or experienced a negative consequence due to substance use, such as a legal infraction, medical or work problems?
☐	☐	33. Have you experienced symptoms of an eating disorder, such as a history of binging, purging by self-induced vomiting or use of laxatives, diuretics or enemas, or restriction of food leading to extreme weight loss?
☐	☐	34. In the last 10 years have you been hospitalized for a mental health or behavioral health condition, or engaged in self-injury or suicidal behavior?

For all applicants, employees or eligible family members:
35. Is there any other medical or mental health condition not covered in questions 1 - 34? ☐ Yes ☐ No

IIA. Explanations required for "Yes" answers to questions 1-35. Attach additional sheets as needed.

Name of Examinee	DOB

III. LIST OF CURRENT MEDICATIONS *(Include prescription, over the counter, vitamins, and herbs)*

Drug Or Other Allergies

IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS *(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.

V. SIGNATURE OF PARENT OR SPONSOR *(I certify I have read and understand the above statement.)*

	Date *(mm-dd-yyyy)*

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.

Name of Examinee	DOB

VI. INSTRUCTIONS FOR COMPLETION AND SUMBISSION 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.

VIII: Clinical Evaluation

1. Height	2. Weight	3. BMI	4. Pulse	5. Blood Pressure *(sitting)*
_____ in. or _____ cm.	_____ lbs. or _____ kgs			If above 140/85 repeat 3 times and record.

IX. 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 / (*Development-children*)				
3. Skin				
4. Eye				
5. Ears/Nose/Throat				
6. Neck/Thyroid				
7. Lungs/Thorax				
8. Breasts				
9. Cardiovascular (*Record murmurs/abnormalities*)				
10. Abdomen				
11. Male Genitalia				
12. Anus/Rectum/Prostate (*if indicated*)				
13. Musculoskeletal / Spine / Extremities (*Note limitations*)				
14. Lymph Nodes				
15. Neurologic				
16. Female Gynecologic (*if indicated*)				

Name of Examinee	DOB

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.

2. Tuberculin Skin Test : **REQUIRED** *(unless previously positive)*
For baseline status as individual who will live overseas in an endemic TB area.

TST Results: _____ mm of induration Date: _____

OR

IGRA Results: _____ Date: _____

Interferon Gamma Release Array: (may substitute for TST if > 5 y/o or In those with previous BCG)

Previous active tuberculosis	☐ Yes	☐ No	Date: _____
Previous positive TST or IGRA	☐ Yes	☐ No	Date: _____
Previous LTBI treatment	☐ Yes	☐ No	Date: _____
Hx of BCG vaccine	☐ Yes	☐ No	Date: _____

3. Chest X Ray *(PA and lateral)* **- Required only if TST > 10mm, positive IGRA or clinically indicated.**

Results: _____

Date: _____

4. ECG *(50 years or older, earlier if indicated)* **- SUBMIT TRACING**

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