

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.

Does your child currently, or have a hisory of:

- | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Frequent/severe headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Fainting, dizzy episodes, or syncope? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Seizures or neurologic disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Eye or vision problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Ear, nose, or throat problems, including hearing loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Allergies or history of anaphylactic reaction? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Cough, wheeze, shortness of breath, asthma? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Murmurs, palpitations, or other heart problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Rheumatic fever? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Diabetes, thyroid, or other endocrine disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Hormonal or metabolic disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Stomach, esophageal, or other intestinal problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Jaundice, hepatitis, gallbladder or other liver disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Intestinal, rectal problems or hernia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15. Anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16. Blood transfusions? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. Urinary or kidney problems, blood in urine? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. Cancer of any type? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19. Premature birth, pre or post-natal complications? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. Joint, tendon or any orthopedic disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21. Rheumatologic or immune disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 22. Malaria, tropical or other infectious disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 23. Any recent unexpected weight loss/gain? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24. Any skin or nail disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 25. History of positive TB skin test, IGRA, or Tuberculosis? |

- | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 26. Has your child been referred or evaluated for any special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 27. Has your child ever been in in psychotherapy or counseling/coaching for the treatment of anxiety, depression/mood problems, psychological trauma, or any other mental health or behavioral health concerns? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 28. Has your child ever been prescribed medication for depression, anxiety, mood, or stress, attention, autism, or any other mental health or behavioral health symptoms? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 29. Has your child ever 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 school problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30. Has your child ever experienced symptoms of an eating disorder, such as a history of bingeing, purging by self-induced vomiting or use of laxatives, diuretics or enemas, or restriction of food leading to extreme weight loss or medical symptoms? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 31. Has your child ever Engaged in self-harm or suicidal behavior? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 32. Has your child ever been hospitalized or in a partial hospital, day-treatment or residential treatment for a mental health or behavioral health condition, or engaged in self-injury or suicidal behavior? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 33. Is there anything else you would like to add about your child's health or well-being that was not addressed in questions 26-32? |

II a. Explanation required for "yes" answers to questions 1-33. Attach additional document.

Name of Examinee	DOB
<input style="width: 90%;" type="text"/> <input style="width: 10%;" type="text"/>	<input style="width: 100%;" type="text"/>

VI. INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DS-1622

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.

EMPLOYEE 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-1622.
- 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-1622 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: *Newborn exam cannot be accepted if completed before four (4) weeks of age*

1. Height/Length _____ in. or _____ cm. _____ percentile	2. Weight _____ lb. or _____ kg. _____ percentile	3. Pulse or HR (REQUIRED FOR ALL AGES, INCLUDING, NEWBORNS)	4. Blood Pressure (<i>age 3 and Over</i>)
5. Head Circumference (<i>18 months and under</i>) _____ in. or _____ cm. _____ percentile	6. Development Appropriate for Age <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, attach Development Screen and explain below with detail in assessment / plan		
	7. Gestational age at birth		
	8. Immunizations Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No Immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No		

IX. PHYSICAL EXAM Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	Notes <i>(Describe each abnormality in detail. Include pertinent item number before each comment)</i>
1. General/Constitution				
2. Development				
3. Skin				
4. Eyes				
5. Ears/Nose/Throat				
6. Neck/Thyroid				
7. Lungs/Thorax				
8. Cardiovascular <i>(Record murmurs/abnormalities)</i>				
9. Abdomen				
10. Genitalia				
11. Anus/Rectum				
12. Musculoskeletal/Spine/ <i>Extremities (Note limitations)</i>				
13. Lymph nodes				
14. Neurologic				

Name of Examinee				DOB
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

X. TUBERCULOSIS SCREENING

1. Tuberculin Skin Test : REQUIRED for ages 1 and over (unless previously positive)
 For baseline status in a child who will live overseas in a likely endemic TB area.

TST Results: _____ mm of induration Date: _____

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: _____

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

SUBMIT REPORT

Results: _____

Date: _____

XI. Assessment or Problem List

XII. Recommendation for Treatment / Further Study / Consultation or Follow - Up

Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address	Telephone Number
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>