



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.**

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

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

	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Malaria, tropical or other infectious disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Any skin or nail disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Cancer of any type?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. 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"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you been prescribed medication for depression, anxiety, mood, or stress, memory/attention, or any other mental health or behavioral health symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you 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?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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.**

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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.

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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.**

Blank area 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
				(Describe every abnormality in detail. Include pertinent item number before each comment.)

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 / ( <i>Development-children</i> )				
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 ( <i>if indicated</i> )				
13. Musculoskeletal / Spine / Extremities (Note limitations)				
14. Lymph Nodes				
15. Neurologic				
16. Female Gynecologic ( <i>if indicated</i> )				

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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.**

**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	