OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

PRE-EMPLOYMENT MEDICAL EVALUATION FOR LOCALLY EMPLOYED STAFF

Section I: Demographic and Employment Information

Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)

Job Title/Section	Post

Type of Evaluation: ☐ Initial ☐ Follow-Up

Section II: Health History

MEDICAL EVALUATION

Do you have any medical restrictions related to performing certain job duties (i.e., have you ever been told by a health professional to avoid doing certain job tasks including lifting, standing for extended periods of time, bending, stooping, etc.)? ☐ Yes ☐ No	If "Yes", describe below
Are you under the care of a medical provider for any medical or mental health conditions? ☐ Yes ☐ No	If "Yes", describe below
Do you have any additional medical/mental health condition(s) for which you are not currently being treated or seen by a health professional? ☐ Yes ☐ No	If "Yes", describe below

MEDICATION

_____ (Initials)	I currently do not take any prescribed, over the counter, controlled, or other medications or supplements. (If initialed, move directly to VISION)

List any current medications/drugs taken either on a routine schedule or as needed. Include all prescribed medications, over-the-counter medications, controlled substances, and/or supplements.

Medication	Dose	How Often (*once a day, as needed, etc.*)	When Started (*mm-yyyy*)	Comments or Additional Information

VISION

☐ Yes ☐ No	Have you ever been told by a health professional that you have a visual impairment?
☐ Yes ☐ No	Do you wear glasses or contact lenses?
☐ Yes ☐ No	Have you ever had procedures to correct your vision?
☐ Yes ☐ No	Have you ever been told by a health professional that you have other problems related to your vision or eyes (e.g., monocular vision, colorblindness, etc.)?

HEARING

☐ Yes ☐ No	Have you ever been told by a health professional that you have hearing loss?
☐ Yes ☐ No	Do you currently wear (or have you ever worn) hearing aids?

Name of Examinee	DOB

Section III: Physical Exam

Part I: Blood Pressure

INSTRUCTIONS: Report systolic and diastolic as numerical values.

Systolic: _____	Diastolic: _____

Part II: Vision

STANDARD: At least 20/40 acuity (Snellen) required in each eye with, or without, correction.

INSTRUCTIONS: When a tool other than the Snellen chart is used, give test results in Snellen-reference values. In recording the distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet (6.096 meters) as denominator. If the candidate wears corrective lenses and will do so while performing official duties, these should be worn while visual acuity is being tested.

NUMERICAL READINGS MUST BE PROVIDED

ACUITY	UNCORRECTED	CORRECTED
Right Eye	20/ _____	20/ _____
Left Eye	20/ _____	20/ _____
Both Eyes	20/ _____	20/ _____

Part III: Hearing

STANDARD: Must perceive forced whisper voice > 5 feet (1.5 meters) with or without a hearing aid.

NUMERICAL READINGS MUST BE PROVIDED

Record distance from individual at which forced whispered voice can first be heard.

Right Ear	Left Ear	
_____ ☐ Feet ☐ Meters	_____ ☐ Feet ☐ Meters	☐ Pass ☐ Fail

Part IV: Review of Symptoms

GENERAL	VISION/EYES	HEARING	CARDIOVASCULAR	RESPIRATORY
☐ Fever	☐ Pain	☐ Tinnitus	☐ Chest Pain	☐ Shortness of breath
☐ Chills	☐ Redness	☐ Hearing Change	☐ Palpitations	☐ Cough
☐ Dizziness	☐ Vision Change			☐ Pain with breath
☐ Weakness				☐ Hemoptysis
ENDOCRINE	**MENTAL HEALTH**	**MUSCULOSKELETAL**	**NEUROLOGICAL**	**OTHER**
☐ Flushing	☐ Irritability	☐ Joint Pain	☐ Headache	☐ _____
☐ Skin Changes	☐ Anxiety	☐ Back Pain	☐ Numbness	☐ _____
☐ Temperature Instability	☐ Depression	☐ Neck Pain	☐ Tingling	☐ _____
☐ Swelling	☐ Mood Changes		☐ Weakness	☐ _____

If any boxes above are checked, explain below.

Name of Examinee	DOB

Part V: Tuberculosis Risk Assessment

STANDARD: All candidates require a risk assessment and should have a chest x-ray (if high or moderate risk) and other testing (if low risk) as required. All candidates MUST complete the DS-6573, *TB Risk Assessment Questionnaire*.

Part VI: Clinical Evaluation

	Normal?	Abnormal?	If abnormal, provide details.
General (alert/oriented, general mental status)	☐	☐	
Cardiovascular/Heart	☐	☐	
Respiratory System	☐	☐	
Musculoskeletal	☐	☐	
Other	☐	☐	
Other	☐	☐	

Local or HU Medical Provider Recommendation

Based on the evaluation/examination of this candidate, I recommend the following (check one of the boxes below, fill in the blanks, and select as needed):

☐ Medically qualified

☐ Not medically qualified, due to: _____

☐ More information needed: _____

Medical Provider Name	Telephone Number

Address/Post

Medical Provider Signature

HU Provider Recommendation (as needed)

Only if required, based on local provider responses and recommendation above

Health Unit Provider Recommendation (check one of the boxes below):

☐ Concur with recommendation above

☐ Modify recommendation as follows: _____

☐ More information needed: _____

Medical Provider Name	Telephone Number

Address/Post

Medical Provider Signature

Paperwork Reduction Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to 5 CFR 339.301 and the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984).

PURPOSE: The information requested on this form will be used to determine employment eligibility for a position with specific medical standards and/or physical requirements.

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. This information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in disqualification of employment.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

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.