U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2024
ESTIMATED BURDEN: 15 minutes
(See Page 2 - Back of Form)

Photo

Surnames	Given Names	Exam Date *(mm-dd-yyyy)*

Birth Date *(mm-dd-yyyy)*	Document Type	Document Number	Case or Alien Number

1. Medical History (*Past or present*)

No	Yes		No	Yes	
☐	☐	**Applicant appears to be providing unreliable or false information, specify in remarks**	☐	☐	**Obstetrics** Pregnant, on day of exam Estimated delivery date *(mm-dd-yyyy)* _____ LMP _____
		General			
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*	☐	☐	Previous live births, number: _____ Birth dates of live births (mm-dd-yyyy) _____ _____
		Cardiology			
☐	☐	Hypertension			
☐	☐	Congestive heart failure or coronary artery disease			
☐	☐	Arrhythmia			
☐	☐	Rheumatic heart disease			
☐	☐	Congenital heart disease			**Sexually Transmitted Diseases** **Previous treatment for sexually transmitted diseases, specify date *(mm-yyyy)* and treatment:**
		Pulmonology	☐	☐	Syphilis _____
☐	☐	Tobacco use: ☐ Current ☐ Former	☐	☐	Gonorrhea _____
☐	☐	Asthma			
☐	☐	Chronic obstructive pulmonary disease			
☐	☐	Tuberculosis history: Diagnosed *(mm-yyyy)* _____ Treatment Completed *(mm-yyyy)* _____ *Diagnosed (mm-yyyy)* _____ *Treatment Completed (mm-yyyy)* _____ *Diagnosed (mm-yyyy)* _____ *Treatment Completed (mm-yyyy)* _____	☐	☐	**Endocrinology** Diabetes
			☐	☐	Thyroid disease
					Hematologic/Lymphatic
			☐	☐	Anemia
			☐	☐	Sickle Cell Disease
			☐	☐	Thalassemia
			☐	☐	Other hemoglobinopathy
☐	☐	Fever			
☐	☐	Cough			
☐	☐	Night sweats			
☐	☐	Weight loss			**Other**
			☐	☐	An abnormal or reactive HIV blood test Diagnosed (*mm-yyyy*) _____
		Psychiatry			
☐	☐	Psychological/Psychiatric Disorder (including major depression, bipolar disorder, or schizophrenia)	☐	☐	Malignancy, specify: _____
☐	☐	Major impairment in learning, intelligence, self-care, memory, or communication	☐	☐	Kidney or Bladder disease
			☐	☐	Chronic liver disease *(including hepatitis B or C)*
☐	☐	Use of substances other than those required for medical reasons	☐	☐	Hansen's Disease History: Diagnosed (*mm-yyyy*): _____ Treatment Completed *(mm-yyyy)* _____
☐	☐	Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)	☐	☐	Food or drug allergies, specify: _____
☐	☐	Substance use or substance induced disorders of substances not on the CSA (including alcohol)	☐	☐	Other medical conditions requiring treatment, specify: _____ _____ _____
☐	☐	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	☐	☐	Disabilities *(including loss of arms or legs),* specify: _____ _____ _____ _____
☐	☐	Ever acted on those thoughts			
		Neurology			
☐	☐	History of stroke			
☐	☐	Seizure disorder			

2. Current Medications *(List all current medications)*

_____
_____
_____

3. Previous Surgeries *(List all previous surgeries)*

_____
_____
_____

4. Vital Signs and Vision

Height _____ cm

Weight _____ . _____ kg

BP (age 15 and up) _____ / _____

Pulse _____ / min

Temperature _____ °C

Respiratory Rate _____ / min

Visual acuity at 6 meters (age 4 and up):

L 6/ _____ R 6/ _____

☐ Corrected ☐ Uncorrected

5. Physical Examination *(include all findings and give details in Remarks)*

N, normal; A, abnormal

N	A		N	A	
☐	☐	General appearance	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	Nutritional status (*including acute malnutrition [wasting] or chronic malnutrition [stunting]*)	☐	☐	Extremities *(including pulses, edema)*
			☐	☐	Exposed Skin
☐	☐	Hearing and ears	☐	☐	Hematologic
☐	☐	Eyes	☐	☐	Nervous system: Sequelae of stroke or cerabral palsy, other neurologic disabilities
☐	☐	Nose, mouth, and throat *(include dental)*			
☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*
☐	☐	Lungs (*auscultation*)			
☐	☐	Abdomen *(including liver, spleen)*	☐	☐	Lymph nodes
☐	☐	Fundal height (if applicable): _____			

6. Mental Health Specialist

☐ No mental health classification

☐ Referral made to mental health specialist. If so, 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)

☐ Class A, with harmful behavior, list disorder(s) _____

☐ Class B, without harmful behavior, list disorder(s) _____

☐ Addiction or abuse of a specific substance on the Controlled Substances Act

☐ Class A, list substance(s) _____

☐ Class B, in remission, list substance(s) _____

7. Syphilis Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date result reported *(mm-dd-yyyy)*	Reactive	Non-reactive	Titer
Screening					
Confirmatory					

Treated		Date (mm-dd-yyyy)	Date (mm-dd-yyyy)	Date (mm-dd-yyyy)
☐ Yes ☐ No	Benzathine penicillin, 2.4 MU IM			
	Other *(therapy, dose)*: _____			
	Treated by panel physician: ☐ Yes ☐ No			

Stage of syphilis *(mark one)*:

☐ Primary ☐ Secondary ☐ Early latent ☐ Late latent or latent of unknown duration ☐ Tertiary ☐ Neurosyphilis ☐ Congenital

8. Gonorrhea Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date result reported *(mm-dd-yyyy)*	Positive	Negative
Screening				

Drug	Dosage	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*

9. Diagnosis and Treatment for Hansen's Disease

Complete this section only if the applicant was diagnosed by the panel physician or was on Hansen's Disease treatment at the time of presentation for their medical examination

Type of Hansen's Disease

- ☐ Multibacillary
- ☐ Paucibacillary

Treatment

- ☐ Partial (≥ 7 days)
- ☐ Completed

Treated by panel physician

- ☐ Yes
- ☐ No

Test Name	Date Result Reported	Positive	Negative

Drug	Dosage	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*

If not treated by panel physician, was referral made by panel physician to another provider for treatment:

- ☐ Yes. Provide facility name: _____
- ☐ No

Diagnosis

- ☐ Initial diagnosis made by panel physician
- ☐ Initial diagnosis made by non-panel physician before medical evaluation by panel physician

If so, year of diagnosis: _____

10. Remarks

_____

_____

_____

_____

_____

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 15 minutes 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 recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

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