



## MEDICAL HISTORY AND EXAMINATION FOR INDIVIDUALS AGE 12 AND OLDER

<b>I. DEMOGRAPHIC INFORMATION TO BE FILLED OUT BY EXAMINEE (OR PARENT)</b>	<b>DATE OF EXAM</b> <i>(mm-dd-yyyy)</i>
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1a. Name of Examinee *(Last, First, MI)*

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1b. Chosen Name of Examinee	2. If Eligible Family Member, Name of Employee/Applicant
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3. Date of Birth of Examinee <i>(mm-dd-yyyy)</i>	4. Place of Birth of Examinee City _____ State _____ Country _____
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5. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	6. Status <input type="checkbox"/> Applicant <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse
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7. Agency of Employee/Applicant/Sponsor

STATE    FCS    FAS    U.S. Agency for Global Media    DoD Civilian    DoD Contractor

Other Government Agency \_\_\_\_\_    Contracting Company \_\_\_\_\_

8. Purpose of Exam

Pre-Employment    In-Service    EFM    Re-Employed Annuitant (REA-WAE)

9. Employment Status of Employee/Applicant/Sponsor

<input type="checkbox"/> Civil Service	<input type="checkbox"/> 3rd Party Contractor	<input type="checkbox"/> Locally Employed Staff (LES)
<input type="checkbox"/> Foreign Service	<input type="checkbox"/> Limited Non-Career Appointment (LNA)	<input type="checkbox"/> Consular Affairs-EFM (CA-EFM)
<input type="checkbox"/> Personal Service Contractor (PSC)	<input type="checkbox"/> Fellow	<input type="checkbox"/> Other: _____

10. E-mail Address of examinee or parent of child < 18 y/o <i>(Where you can be reached to discuss examinee medical information)</i> Primary: _____ Alternate: _____	11. Assignment Type <input type="checkbox"/> Temporary Duty (Regional hub or CONUS based) <input type="checkbox"/> Permanent Change of Station/Post of Assignment
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12. Telephone Number of examinee or parent of child < 18 y/o <i>(Where you can be reached to discuss examinee medical information)</i> Primary: _____ Alternate: _____	13. Post of Assignment and Estimated Date of Arrival <i>(if applicable)</i> Proposed Post: _____ EDA (mm-dd-yyyy): _____ <i>*If the above is an ESCAPE post, please complete a DS-6570 form.</i>
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**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
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III. LIST OF CURRENT MEDICATIONS AND DOSAGES <i>(Include prescription, over the counter, vitamins, and herbs)</i>			Drug Or Other Allergies

IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS <i>(Include all medical and psychiatric illnesses)</i>			
Date <i>(mm-dd-yyyy)</i>	Illness or Operation	Name of Hospital	City and State

V. SPECIALTY CARE <i>(if applicable)</i>			
1. Have you been advised to see a specialist more than once a year for a medical/mental health condition? <i>(Check all that apply)</i>			
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Nephrologist	<input type="checkbox"/> Pulmonologist	
<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Neurologist	<input type="checkbox"/> Rheumatologist	
<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Hematologist/Oncologist	<input type="checkbox"/> Psychiatrist/Mental Health Provider		

**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.**

VI. SIGNATURE OF EXAMINEE OR PARENT <i>(I certify I have read and understand the above statement.)</i>	
	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
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**VII. 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. 4), and provide follow-up recommendations (pg. 5).
  - Medical Examiner must sign on page 5.

- EXAMINEE / SPONSOR / PARENT**
- All fields on page 1 through 3 must be filled out. Examinee or parent/employee sponsor must sign on page 3.
  - 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).

**VIII: 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 on significant patient medical history and items checked "yes" on page 2/section II.

**IX: 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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<b>X. Clinical Evaluation</b> Check each item as indicated. Check "NE" if not evaluated.	Normal	Abnormal	NE	<b>Notes</b> (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 ( <i>Record murmurs/abnormalities</i> )				
10. Abdomen				
11. Male Genitalia				
12. Anus/Rectum/Prostate ( <i>if indicated</i> )				
13. Musculoskeletal / Spine / Extremities ( <i>Note limitations</i> )				
14. Lymph Nodes				
15. Neurologic				
16. Female Gynecologic ( <i>if indicated</i> )				

Name of Examinee	DOB
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<b>XI. LABORATORY ANALYSIS</b>	<b>COPIES OF LABORATORY REPORTS MUST BE ATTACHED</b>
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- 1. Required Labs**
- A. Hematology** (Hematocrit, Hemoglobin, White Blood Cell Count, and Platelets)
  - B. Chemistry** (Fasting Blood Sugar, Creatinine, and ALT. Hemoglobin A1c if indicated)
  - C. Serology** (HEP B Surface **ANTIGEN**, HEP C Antibody, RPR/VDRL, and HIV I/II Antibody, and G6PD)
  - 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.**

<p><b>2. Tuberculin Skin Test : <u>REQUIRED</u></b> <i>(unless previously positive)</i></p> <p>TST Results: _____ mm of induration    Date: _____</p> <p style="text-align: center;"><b>OR</b></p> <p>IGRA Results: _____    Date: _____</p> <p><i>Interferon Gamma Release Array: (may substitute for TST if &gt; 5 y/o or In those with previous BCG)</i></p> <p>Previous active tuberculosis    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Date: _____</p> <p>Previous positive TST or IGRA    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Date: _____</p> <p>Previous LTBI treatment    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Date: _____</p> <p>Hx of BCG vaccine    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Date: _____</p>	<p><b>3. Chest X Ray (PA and lateral) - Required only if TST &gt; 10mm, positive IGRA or clinically indicated.</b></p> <p>Results: _____</p> <p>Date: _____</p> <hr/> <p><b>4. ECG (50 years or older, earlier if indicated) - SUBMIT TRACING</b></p> <p>Results: _____</p> <p>Date: _____</p>
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<b>XII. Assessment or Problem List</b>	<b>XIII. Recommendation for Treatment / Further Study / Consultation or Follow - Up</b>
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**NOTICE:** This form is not complete until all laboratory tests and results from section XI are attached and included with this DS-1843 form.

Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
Address	Telephone Number	