U.S. Department of State
Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

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EXPIRATION DATE: 08-31-2020
ESTIMATED BURDEN: 1 HOUR

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE
FOR INDIVIDUALS AGE 12 AND OLDER

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 on this form will be used to make appropriate medical clearance decisions.
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

I. DEMOGRAPHIC INFORMATION
TO BE FILLED OUT BY EXAMINEE (OR PARENT)

DATE OF EXAM *(mm-dd-yyyy)*

1. Name of Examinee *(Last, First, MI)*

2. If Eligible Family Member, Name of Employee/Applicant

3. Date of Birth *(mm-dd-yyyy)*

4. MED ID (*if available*)

5. Sex
☐ Male ☐ Female

6. Place of Birth
City _____ State _____ Country _____

7. Status
☐ Applicant ☐ Employee ☐ Spouse
☐ Dependent Child ☐ Domestic Partner

8. Foreign Service Agency
☐ STATE ☐ USAID ☐ Foreign Commercial Service ☐ Foreign Agricultural Service ☐ Board of Broadcasting Governors

9. Health Insurance Plan

10. E-mail Address *of examinee or parent of child < 18 y/o*
(Where You can be Reached for the Next 90 days)

11. Purpose of Exam
☐ Pre-Employment Exam
☐ In-Service Exam
☐ Separation Exam

12. Telephone Number of examinee or parent of child < 18 y/o
(Where You can be reached for the Next 90 days)

13. Post of Assignment and Estimated Dates of Arrival / Departure
a. Proposed Post _____ EDA _____ *(mm-dd-yyyy)*
b. Present Post _____ EDD _____ *(mm-dd-yyyy)*
c. Last 3 Posts _____

14. Mailing Address
(*Where You can be reached for the Next 90 days*)

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

II. MEDICAL HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS: *For YES answers, provide a brief explanation, attach additional sheets, if needed.*

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

Yes No

- ☐ ☐ 1. Frequent/severe headaches or migraines?
- ☐ ☐ 2. Fainting or dizzy episodes?
- ☐ ☐ 3. Stroke, TIA or head injury?
- ☐ ☐ 4. Epilepsy, seizures or other neurologic disorders?
- ☐ ☐ 5. Chronic eye or vision problems?
- ☐ ☐ 6. Ear, nose, throat problems; hearing loss, hoarseness?
- ☐ ☐ 7. Allergies or history of anaphylactic reaction?
- ☐ ☐ 8. Shortness of breath, asthma, or COPD?
- ☐ ☐ 9. History of abnormal chest x-ray?
- ☐ ☐ 10. History of positive TB skin test or tuberculosis?
- ☐ ☐ 11. Aneurysm, blood clot or pulmonary embolism?
- ☐ ☐ 12. High blood pressure?
- ☐ ☐ 13. Heart problems, murmur or palpitations?
- ☐ ☐ 14. Have you smoked any cigarettes in the last month?
- ☐ ☐ 15. Stomach, esophageal, intestinal problems?
- ☐ ☐ 16. Jaundice or hepatitis (type)?
- ☐ ☐ 17. Intestinal, rectal problems or hernia?
- ☐ ☐ 18. Urinary or kidney problems, blood in urine?
- ☐ ☐ 19. Diabetes or thyroid disorder?
- ☐ ☐ 20. Joint or back pain/injury?

Yes No

- ☐ ☐ 21. Rheumatologic disorder?
- ☐ ☐ 22. Anemia?
- ☐ ☐ 23. Blood transfusion?
- ☐ ☐ 24. Malaria or other tropical disease?
- ☐ ☐ 25. Any skin or nail disorder?
- ☐ ☐ 26. Cancer of any type?
- ☐ ☐ 27. Any thickening or lump in breast, testicle?

Yes No

- ☐ ☐ 28. Have you consumed at any one time in the past year, more than 5 alcohol drinks for males or 4 drinks for females? Explain.

IN THE PAST SEVEN (7) YEARS (for questions 29-33)
(parents - please answer for children < 18 years of age)

- ☐ ☐ 29. Have you used marijuana, amphetamines, narcotics, cocaine, or hallucinogenic drugs?
- ☐ ☐ 30.Have you been in psychotherapy/counseling or been prescribed medication for depression, anxiety, mood or stress?
- ☐ ☐ 31. Have you felt unusually depressed, sad, blue, or had frequent crying spells which lasted more than two weeks at a time?
- ☐ ☐ 32. Have you had frequent or recurrent episodes of: difficulty in relaxing or calming down, panicky feelings, irritability, anger, feeling hyper, or nervousness?
- ☐ ☐ 33. Have you experienced any emotional or physical symptoms related to a past trauma?

Children Only: ☐ Yes ☐ No 34. Has your child been referred for any current or potential special educational services, accommodations, or modifications (i.e.: IFSP, Early Intervention, IEP, 504 Plan)? Explain:

Women: (provide results if applicable, N/A if not applicable)

35. Date of last PAP test?_____ Results: _____
36. Date of last Mammogram?_____ Results: _____
☐ Yes ☐ No Are you pregnant? Est. due date: _____

Men/Women: Colon Cancer Screening:
(*provide results if applicable, N/A if not applicable*)

38. Date of last colon cancer screening, if applicable: _____
Test (colonoscopy/sigmoidoscopy/guiacFOBT): _____
Results: _____

For all applicants, employees or eligible family members:
39. Is there any other medical or mental health condition not covered in questions 1 - 38? ☐ Yes ☐ No Explain:

IIA. Explanations required for "Yes" answers to questions 1-39. Attach additional sheets as needed.

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 EXAMINEE OR PARENT OF CHILD <18 Y/O *(I certify I have read and understand the above statement.)*

	Date *(mm-dd-yyyy)*

Name of Examinee	DOB

V. INSTRUCTIONS FOR COMPLETION AND SUMBISSION OF FORM DS-1843

MEDICAL EXAMINER

- Medical Examiner must comment on positive history on page 2. Medical Examiner must comment on physical findings and provide recommendations for treatment/further study/consultations of medical & mental health problems.
- 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). The preferred method to submit the DS - 1843 (and supporting documentation) is to scan and email in PDF format to: **MEDMR@state.gov**. If it is not possible to scan, please fax to Medical Records department **FAX: 703-875-4850**. If you wish to confirm that your exam forms were received, please email **MEDMR@state.gov**.

VI: Medical Examiner comments on significant patient medical history and items checked "yes" on page 2/section II. Use additional pages if needed.

VII: Clinical Evaluation

1. Height	2. Weight	3. BMI	4. Pulse	5. Blood Pressure *(sitting)*
_____ in. or _____ cm.	_____ lbs. or _____ kgs			If above 140/85 repeat 3 times and record.

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

Name of Examinee	DOB

IX. LABORATORY ANALYSIS: All tests are required unless otherwise specified. Test results from previous 12 months are acceptable. COPIES OF LABORATORY REPORTS MUST BE SUBMITTED FOR REVIEW AND MUST BE IN ENGLISH

1. Hematology	2. Chemistry	3. Serology	4. Urinalysis *(only if indicated)*
Hematocrit _____ %	Fasting Blood Sugar _____	HEP B Surface Antigen _____	WBC _____
or			
Hemoglobin _____ gms%	HgA1C (*if indicated*) _____	HEP C Antibody _____	RBC _____
WBC _____ /cmm	Creatinine _____	RPR/VDRL _____	Protein _____
Platelets _____	ALT _____	HIV I/II Antibody _____	Other _____

5. Tuberculin Skin Test*: Required for ages 1 and over (unless previously positive)*

Results: _____ mm of induration Date: _____

Interferon Gamma Release Assay: (may substitute for TST if > 5 y/o or In those with previous BCG)

Results: _____ Date: _____

If no TB screening performed, explain why:

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: _____

Other: _____

6. Chest X Ray *(PA and lateral)* - submit report

Pre-Employment : Required for applicant/family member > 18 years old

In-service Exam : Required for those with > 10 mm TST newly identified or positive IGRA **OR** when clinically indicated

Results: _____ Date: _____

7. ECG *(50 years or older, earlier if indicated)* - submit tracing

Results: _____

Date: _____

OPTIONAL TESTS: The following tests may be performed at the discretion of the Examiner, with patient consent. They are not required for a medical clearance determination. If performed, results may be used in the provision of care to individuals covered under the Department of State Medical Program. *Cancer screening tests should be performed as indicated by age, medical history/risk and current cancer screening guidelines

8. Blood Type *(if not previously documented)* Type: ABO _____ (Rh) Dμ: _____ (weak D): _____

9. G6PD *(If not previously documented)* for malarial prophylaxis Results: _____ Date: _____

10. PAP/Cervical Cytology Results: _____ Date: _____

11. Mammogram Results: _____ Date: _____

12. Colon Cancer Screen

Test (colonoscopy/sigmoidoscopy/guiac FOBT/other): _____ Results: _____ Date: _____

X. Assessment or Problem List	XI. Recommendation for Treatment / Further Study / Consultation or Follow - Up

Typed Name of Examiner	Signature of Examiner	Date *(mm-dd-yyyy)*

Examining Facility	Telephone Number

Address