



MEDICAL HISTORY AND EXAMINATION FOR INDIVIDUALS AGE 12 AND OLDER

I. DEMOGRAPHIC INFORMATION TO BE FILLED OUT BY EXAMINEE (OR PARENT)		DATE OF EXAM (mm-dd-yyyy)
1a. Name of Examinee (Last, First, MI) 		
1b. Chosen Name of Examinee		2. If Eligible Family Member, Name of Employee/Applicant
3. Date of Birth of Examinee (mm-dd-yyyy)		4. Place of Birth of Examinee City _____ State _____ Country _____
5. Sex ☐ Female ☐ Male	6. Status ☐ Applicant ☐ Employee ☐ New Family Member ☐ Dependent Child ☐ Spouse	
7. Agency of Employee/Applicant/Sponsor ☐ STATE ☐ USAID ☐ FCS ☐ FAS ☐ U.S. Agency for Global Media ☐ DoD Civilian ☐ DoD Contractor ☐ Other Government Agency _____ ☐ Contracting Company _____		
8. Health Insurance Plan	9. Purpose of Exam ☐ Pre-Employment Exam ☐ In-Service Exam ☐ Separation Exam ☐ REA-WAE	10. Employment Status ☐ Civil Service ☐ LES ☐ FS Officer ☐ LNA ☐ PSC Contractor ☐ Fellow ☐ 3rd Party Contractor ☐ EPAP ☐ CA-EFM ☐ Other
11. E-mail Address of examinee or parent of child < 18 y/o (Where You can be Reached for the Next 90 days) Primary: _____ Alternate: _____	13. Special Assignment (If applicable) ☐ TDY (Regional hub or CONUS based) ☐ Iraq - List Post _____ ☐ Other ESCAPE Post(s) If yes, list _____	
12. Telephone Number of examinee or parent of child < 18 y/o (Where You can be Reached for the Next 90 days) Primary: _____ Alternate: _____	14. Post of Assignment and Estimated Dates of Arrival / Departure a. Proposed Post _____ EDA _____ (mm-dd-yyyy) b. Present Post _____ EDD _____ (mm-dd-yyyy)	
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.		

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ANSWER THE FOLLOWING QUESTIONS: ALL YES ANSWERS MUST HAVE A WRITTEN EXPLANATION WITH DATE OF OCCURENCE IN BOX IIA.																																																																																																																			
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Name of Examinee	DOB
III. LIST OF CURRENT MEDICATIONS <i>(Include prescription, over the counter, vitamins, and herbs)</i>	
IV. HOSPITALIZATIONS/OPERATIONS/MEDICAL EVACUATIONS <i>(Include all medical and psychiatric illnesses)</i>	
Date <i>(mm-dd-yyyy)</i>	Illness or Operation

Name of Examinee	DOB
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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. 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).
- 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.

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

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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.)
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
X. 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 : <u>REQUIRED</u> <i>(unless previously positive)</i> For baseline status as individual who will live overseas in an endemic TB area. TST Results: _____ mm of induration Date: _____ OR IGRA Results: _____ Date: _____ <i>Interferon Gamma Release Array: (may substitute for TST if > 5 y/o or In those with previous BCG)</i> 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: _____	
XI. Assessment or Problem List	4. ECG (50 years or older, earlier if indicated) - SUBMIT TRACING Results: _____ Date: _____	
XI. Assessment or Problem List	XII. Recommendation for Treatment / Further Study / Consultation or Follow - Up	
NOTICE: This form is not complete until all laboratory tests and results from section X are attached and included with this DS-1843 form.		
Typed Name of Examiner	Signature of Examiner	Date (mm-dd-yyyy)
Address	Telephone Number	