U.S. Department of State

Office of Medical Services, Room L101, SA-1, Washington, DC 20522-0102

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

FOR CHILDREN 12 YEARS AND OVER

***OMB APPROVAL NO. 1405-0068**
EXPIRATION DATE: 5-31-2009
ESTIMATED BURDEN: 1 HOUR

PRIVACY ACT NOTICE: This information is requested pursuant to the Foreign Service Act of 1980, as amended *(22 U.S.C. 3084, 3901 and 3984)*. The primary purpose for soliciting this information is to make appropriate assignments abroad. Unless otherwise protected by medical privacy regulations, the information solicited on this form may be made available to appropriate agencies, whether federal, state, local or foreign, for law enforcement and administration purposes. It may also be disclosed pursuant to court order. Failure to provide this information may result in denial of a medical clearance and affect your Foreign Service eligibility.

I. To Be Filled Out By Examinee *(complete all sections, type or in ink).*

Date *(mm-dd-yyyy)*

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

2. Full Name of Employee/Applicant/Sponsor

3. Social Security Number *(Employee/Applicant/Sponsor)*

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

5. Sex ☐ Male ☐ Female

6. Place of Birth

City ____________ State ________ Country ________

7. Status ☐ Applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other

8. Name of your Health Insurance Plan

9. Purpose of Exam ☐ Pre-employment ☐ Separation ☐ In Service

10a. Agency of Employee/Applicant/Sponsor ☐ State ☐ USAID ☐ Other ________

10b. Type of Employment ☐ Foreign Service ☐ Contractor ☐ Civil Service Excursion Tour

11. Mailing Address
(Medical Clearance Abstract will be mailed to listed address)

Telephone Number *(where you can be reached for the next 90 days)* ____________

E-mail Address *(where you can be reached for the next 90 days)* ____________

12. Post of Assignment and Dates of Departure/Arrival

a. Proposed Post ____________

EDA ________ *(mm-dd-yyyy)*

b. Present Post ____________

EDD ________ *(mm-dd-yyyy)*

c. Last 3 Posts ____________

13. Check and Describe Medical Conditions of Blood Relatives. Include Cancer, Alcoholism, Diabetes, Heart or Kidney Disease, High Blood Pressure, Mental Health Disorder, or Learning Disabilities.

☐ Father ____________
☐ Mother ____________
☐ Grandmother(s) ____________
☐ Grandfather(s) ____________
☐ Sister(s) ____________
☐ Brother(s) ____________
☐ Aunt(s) ____________
☐ Uncle(s) ____________

14. Marital Status ☐ Married ☐ Never Married ☐ Other

15. Are You Adopted? ☐ Yes ☐ No

DO NOT WRITE IN THE SPACE BELOW ***(FOR USE BY MEDICAL DIVISION ONLY)***

Clearance Action

***Public reporting burden for this collection of information is estimated to average 1 hour per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to:**

II. Have You Had In The Past 10 Years: | **Name of Examinee:**

Yes	No	
☐	☐	1. Frequent or severe headaches?
☐	☐	2. Dizzy spells, fainting, or seizures?
☐	☐	3. Neurological disorders?
☐	☐	4. Chronic eye trouble, or vision problems? Date of last eye exam: ______
☐	☐	5. Tooth or gum problems?
☐	☐	6. Ear, nose, or throat problems, including hearing difficulties, hoarseness, or allergies?
☐	☐	7. Cough, wheezing, shortness of breath or asthma?
☐	☐	8. Abnormal chest X-ray
☐	☐	9. History of positive TB skin test or clinical tuberculosis, TB exposure, or BCG vaccination?
☐	☐	10. Palpitations, chest pressure, murmurs or any other heart problems?
☐	☐	11. History of aneurysm or blood clots?
☐	☐	12. High blood pressure or hypercholesterolemia?
☐	☐	13. Esophagus, stomach, intestinal, rectal, liver, or gallbladder problems?
☐	☐	14. Hernia?
☐	☐	15. Have you had a colonoscopy or sigmoidoscopy? Date ______
☐	☐	16. A change in urinary habits, urinary tract infection or stones, blood or protein in urine?
☐	☐	17. Sexually-transmitted disease?
☐	☐	18. Serious infection?
☐	☐	19. Cancer of any type?

Yes	No	
☐	☐	20. Rheumatologic-problems; tendon, joint or back pain/injury; bone-deformity or fracture?
☐	☐	21. Malaria or other tropical disease?
☐	☐	22. Any hair, nail or skin problems or disorders?
☐	☐	23. Diabetes; thyroid or other hormonal/metabolic disease?
☐	☐	24. Anemia or blood transfusion?
☐	☐	25. Have you ever had an organ transplant or been an organ donor?
☐	☐	26. Recent gain or loss of 10 lbs or more?
☐	☐	27. Thickening or lump in breast, testicle or elsewhere?
☐	☐	28. Felt unusually depressed, sad, blue or had frequent crying spells?
☐	☐	29. Difficulty in relaxing or calming down; felt panicky, irritable, angry, hyper or nervous?
☐	☐	30. Special education needs?
☐	☐	31. Have you ever used tobacco products?
☐	☐	32. Have you ever used alcohol?
☐	☐	33. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years?
☐	☐	34. Have you ever been referred to or received mental health treatment?
☐	☐	35. Do you practice safe sex?
☐	☐	36. Are you at risk for AIDS?
☐	☐	37. Do you exercise?
☐	☐	38. Are you careful with your diet?
☐	☐	39. Do you have a living will?
☐	☐	40. Other?

Women Only

Yes	No	
☐	☐	41. Do you have menstrual cycles? Date of last menstrual period ______
☐	☐	42. Have you had an abnormal PAP test in the last 5 years? Date of last PAP test ______ Date of abnormal PAP test ______ Result ______
☐	☐	43. Have you ever had a mammogram?
☐	☐	44. Have you ever had breast implants?
☐	☐	45. Are you pregnant?
☐	☐	46. Are you nursing?

Pregnancy History: *(number of times)*

Pregnant ______ Miscarriages ______ Live births ______

Premature births ______ Abortions ______ Living children ______

III. Hospitalizations/Operations/Medical Evacuations *(Include All Medical and Psychiatric Illnesses)*

Date *(mm-dd-yyyy)*	**Illness or Operation**	**Name of Hospital**	**City and State**

Please Recheck All Items for Completeness and Accuracy. DO NOT INDICATE: "Previously Answered."

IV. Explanations required for "yes"answers to questions 40 to 43 and 47 to 51. Attach additional sheet.

The intentional omission of any crucial medical information is a criminal offense *(Section 1001 of the U.S.C. Title 18)*. Pre-employment applicants who intentionally omit information which would make them ineligible for appointment, will be subject to disciplinary action, including separation for cause if they are hired. Current employees may also be subject to disciplinary action for intentional omission of information.

Signature of Examinee *(I certify I have read and understand the above statements).* | Date *(mm-dd-yyyy)*

V. Examiner Comments on Significant History and Examination Findings: Comment on all items checked YES in section II.

VI. To Be Completed By The Examiner

Name Of Examinee:

1. Race *(check one)* *(needed for genetic risk factors)*	2. Height	3. Weight	4. Pulse	5. Blood Pressure *(sitting)* If above 140/85 repeat 3 times and record. If consistently elevated consider treatment.
☐ White ☐ Black ☐ Other *(specify)* ____________	________ in. or ________ cm.	________ lbs. or ________ kgs.		

VII. Clinical Evaluation

Check each item as indicated. Check "NE" if not evaluated.

	Normal	Abnormal	NE	**Notes** *(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)*
1. General/Constitution				
2. Skin				
3. Eyes				
4. Ears/Nose/Throat				
5. Neck/Thyroid				
6. Lungs/Thorax				
7. Breasts				
8. Cardiovascular				
9. Abdomen				
10. Male Genitalia				
11. Anus/Rectum/Prostate				
12. Musculoskeletal				
13. Lymphatic				
14. Neurological				
15. Female Gynecologic				
16. Miscellaneous				
17. Papanicolaou done ☐ Not done ☐ Reason if not done				
18. Attach cytology report.				

VIII. List Current Medications *(Include prescription, over the counter, vitamins, and herbals)*

Drug Or Other Allergies

____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

IX. Instructions To The Examiner

Importance of Examination: It is important for the examiner to identify all medical conditions requiring follow-up medical care or that could be adversely affected by environmental conditions such as high altitude, air pollution, and poor sanitation. The consequences of not identifying preexisting health problems could be extremely serious for the examinee. As you perform the examination, keep in mind that the examinee may be assigned to a third world developing country where medical care is not available.

Disposition of Reports: All reports must be in English and be identified with the full name and date of birth of the examinee, All reports should be placed in a sealed envelope and marked, "Privileged Medical Information." If abroad, the report should be returned to the Embassy. If in the U.S., the report should be mailed to: Medical Records, Room L101, SA-1, U.S. Department of State, 2401 E St. NW Washington, DC 20522-0102.

Examination Fees: Reimbursement of a reasonable and customary fee will be made for each examination, including laboratory tests and X-ray procedures. Please itemize tests and cost of each. Submit first to insurance, and then any remaining bills to: Medical Claims, Room L101, SA-1, U.S. Department of State 2401 E St. NW, Washington DC 20522-0102.

Note: Recommend that a copy of examination be given to examinee.

X. All Tests Required Unless Otherwise Specified. **Please Attach All Reports.** | **Name of**

1. Hematology

Hematocrit ____________ %
or
Hemoglobin ____________ gms%

WBC ________________ /cmm

Differential

Granulocytes ______________ %

Lymphocytes ______________ %

Eosinophils ______________ %

Other ____________________ %

7. Urinalysis *(pre-employment, separation and when indicated)*

Specific Gravity ________________ WBC ________________

Albumin ________________ RBC ________________

Sugar ________________ Casts ________________

____

2. Screening Chemistry *(pre-employment and at least every 5 years)*

Blood Sugar ______________ Creatinine ______________

Cholesterol ______________ ALT ______________

HDL/LDL ______________ GGT ______________

Triglycerides ______________ HbA1C *(when indicated)* __________

8. ECG *(50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings).*

Results

9. Chest X-Ray *(required for persons 18 years and over for pre-employment and separation, for new TB skin test converters or when indicated. If pregnant, baseline chest X-ray required after delivery)*

Date *(mm-dd-yyyy)* ______________ Results ______________________

3. Serology *(specify test and results) (12 years and over for pre-employment and approx. every 5 years after)*

RPR/VDRL ________________________________

HIV I/II antibody ________________________________

HepB surface antigen ________________________________

HepC antibody ________________________________

10. Tuberculin Test *(5TU PPD)* *(recommended for all examinees including those with previous BCG)*

Date *(mm-dd-yyyy)* ________________

If Not Done, Explain ______________

Results: ______________ mm of Induration

Previous Positive Yes _____ No _____

Previous Rx Complete Yes _____ No _____

Date Completed *(mm-dd-yyyy)* ____________

New Converter Yes _____ No _____
(X-Ray required)

Treatment

11. Pre-employment and in Service if not previously done. *(not for separation)*

a. Blood Type

ABO __________

(Rh) D __________

(weak) D^u __________

b. G6PD

Normal __________

Deficient __________

4. Stool Exam for Occult Blood *(50 years or earlier when indicated)*

a. Pos _______ Neg _______

b. Pos _______ Neg _______

c. Pos _______ Neg _______

5. Colon Screen *(age 50 or when indicated by risk factors according to current standards of care)*

FFS, Barium Enema, or Colonoscopy.

Attach most recent results.

6. PSA *(50 years or earlier when indicated.)*

12. Mammogram *(required age 50 years and over, recommended age 40 and over)*

XI. Assessment Or Problem List

XII. Recommendation for Treatment/Further Study/Consultation or Follow-Up

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

Examining Facility

Telephone Number ________________________________

Fax Number ________________________________

Address