U.S. Department of State
Office of Medical Clearances, Room L209, SA-1, Washington, DC 20522-0102

MEDICAL HISTORY AND EXAMINATION FOR FOREIGN SERVICE

For persons 12 years and over

*OMB APPROVAL NO. 1405-0068
EXPIRATION DATE: 09-30-2005
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 determine medical eligibility to enter the Foreign Service and 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, Middle)*

2. IF FAMILY MEMBER, NAME OF EMPLOYEE *(Applicant)*

3. SOCIAL SECURITY NUMBER *(Employee or Applicant)*

4. DATE OF BIRTH *(mm-dd-yyyy)*

5. SEX ☐ MALE ☐ FEMALE

6. PLACE OF BIRTH
City _____ 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
☐ State ☐ USAID ☐ Other _____

10b TYPE OF EMPLOYMENT
☐ Foreign Service Officer ☐ Contractor ☐ Civil Service Excursion Tour

11. MAILING ADDRESS ***(Medical Clearance Abstract and all clearance correspondence will be mailed to listed address)***

12. POST OF ASSIGNMENT/DATES OF DEPARTURE/ARRIVAL
a. Proposed _____ EDA _____
b. Present Post _____ EDD _____
c. Last 3 Posts _____

TELEPHONE NUMBERS: ***(where you can be reached for the next 90 days)***
_____ _____

E-MAIL ADDRESSES: ***(where you can be reached for the next 90 days)***
_____ _____

13. FAMILY HISTORY

	Family Member Accompanying Employee	Age	Chronic Health Condition	If Dead, Cause of Death	Age at Death
Spouse					
Child					
Child					
Child					
Child					
Child					

14. CHECK AND DESCRIBE MEDICAL CONDITIONS OF BLOOD RELATIVES. INCLUDE CANCER, ALCOHOLISM, DIABETES, HEART, OR KIDNEY DISEASE, HIGH BLOOD PRESSURE, MENTAL HEALTH

☐ Father _____
☐ Mother _____
☐ Grandmother(s) _____
☐ Grandfather(s) _____
☐ Sisters _____
☐ Brothers _____
☐ Aunts and Uncles _____

15. MARITAL STATUS ☐ Married ☐ Never Married ☐ Other

16. ARE YOU ADOPTED? ☐ YES ☐ NO

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

IMIMS #:

CLEARANCE ACTION:

*Public reporting burden for this collection of information is estimated to average 60 minutes 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: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

II. HAVE YOU HAD IN THE PAST 10 YEARS: | **NAME OF EXAMINEE:**

YES	NO		YES	NO	
☐	☐	1. Frequent or severe headaches?	☐	☐	22. Frequent indigestion or heartburn?
☐	☐	2. Dizzy spells, fainting, or blackouts?	☐	☐	23. Gallbladder trouble or gallstones?
☐	☐	3. Epilepsy or seizures?	☐	☐	24. Rupture or hernia?
☐	☐	4. Chronic eye trouble, vision problems, or glaucoma? Date of last eye exam. _____	☐	☐	25. A change in bowel or bladder habits?
			☐	☐	26. Hemorrhoids (piles) or other rectal problems?
☐	☐	5. Chronic tooth or gum problems?	☐	☐	27. Rectal bleeding or black, tarry stools?
☐	☐	6. Difficulty with your hearing?	☐	☐	28. Have you had a colonoscopy or sigmoidoscopy? Date _____
☐	☐	7. Hoarseness of your voice?	☐	☐	29. Frequent urination or chronic urinary tract
☐	☐	8. Other ear, nose, or throat problems?	☐	☐	30. Kidney trouble; stone, blood or protein in urine?
☐	☐	9. Hay fever or other allergies?	☐	☐	31. Sugar in urine or diabetes?
☐	☐	10. Asthma?	☐	☐	32. Arthritis, rheumatism, or joint pains?
☐	☐	11. Wheezing or shortness of breath?	☐	☐	33. Back pain or back injury?
☐	☐	12. Abnormal chest X-ray?	☐	☐	34. Joint or bone deformity or fracture?
☐	☐	13. History of positive TB skin test?	☐	☐	35. Malaria, dysentery, other tropical disease?
☐	☐	14. Chronic cough or coughing up blood?	☐	☐	36. A sore that does not heal, change (color, size) in a mole or wart?
☐	☐	15. Pain or pressure in your chest?	☐	☐	37. Skin cancer?
☐	☐	16. Palpitations or pounding heart?	☐	☐	38. Recent gain or loss of 10 lbs or more of weight?
☐	☐	17. Heart problem, murmur or infection?	☐	☐	39. A thickening or lump in breast or elsewhere?
☐	☐	18. High blood pressure?	☐	☐	40. Frequent crying spells?
☐	☐	19. Difficult swallowing?	☐	☐	41. Felt unusually depressed, sad or "blue"?
☐	☐	20. Stomach, liver, or intestinal	☐	☐	42. Difficulty in relaxing or calming down, panicky, irritable, angry, hyper or nervous?
☐	☐	21. Jaundice or hepatitis (which type)?	☐	☐	43. Special Education needs?

YES	NO	
☐	☐	44. Do you smoke or chew tobacco now? If so, what and how much? _____
☐	☐	45. If you stopped smoking cigarettes or using tobacco, when was it? _____
☐	☐	46. Do you drink alcohol? If yes, how much _____
☐	☐	47. Have you ever felt you ought to cut down on your drinking or felt guilty about your drinking?
☐	☐	48. Have you ever been annoyed by people criticizing your drinking?
☐	☐	49. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years? **Explain if yes.**
☐	☐	50. Have you EVER been referred to or sought consultation or treatment from a mental health professional (counselor, psychologist, psychiatrist, social worker, pastoral or family marriage counselor Attach report from provider.
		51. Have you EVER received mental health treatment as an inpatient or as an outpatient in a day treatment center?

WOMEN ONLY:

YES	NO	
☐	☐	If you are past menopause, have you had any vaginal bleeding?
☐	☐	Any change in your periods, or bleeding between periods?
		When was your last PAP test? *(mm,yyyy)* _____
☐	☐	Have you had an abnormal PAP test in the last 5 years? Date of abnormal PAP test *(mm,yyyy)*. _____ Result _____
☐	☐	Have you ever had a mammogram? Last date *(mm,yyyy)?* _____
☐	☐	Have you ever had an abnormal mammogram *(mm,yyyy)?* _____
☐	☐	Have you ever had a breast biopsy? Date of biopsy *(mm,yyyy)?* _____ Result _____

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-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 *(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.	_____ lb. or _____ kg.		

VII. CLINICAL EVALUATION Check each item as indicated. Enter "NE" if not evaluated.	Normal	Abnormal	**NOTES** *(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)*
1. Skin *(Record Lesions, Body Marks and Surgery Scars)*			
2. Head, Neck, Thyroid			
3. Ear, Nose and Throat			
4. Lymph Nodes			
5. Eyes *(Include Funduscopic Exam)*			
6. Lungs			
7. Breasts			
8. Heart *(Record Murmurs and Abnormalities)*			
9. Abdomen *(Comment on Liver and Spleen)*			
10. Genitalia *(Male-Testes Descended?* Masses?)			
11. Anus, Rectum and Prostate *(required at age 40 and over)*			
12. Vascular System *(Record Peripheral Pulses and Varicosities)*			
13. Extremities and Spine			
14. Neurological *(Record Reflexes and Muscle Strength)*			
15. Psychiatric *(Specify Any Significant Mood, Cognitive, Behavioral Observations)*			
16. GYN *(Bimanual Exam Required for Female Examinees 21 Years and Over, or When Indicated)*. Describe Abnormalities			

17. Papanicolaou done ☐ Not done ☐ Reason if not done

18. Attach cytology report.

ADDITIONAL COMMENTS

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 WHICH WILL REQUIRE FOLLOW-UP MEDICAL CARE OR 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 CLEARANCES, Room L209 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 any remaining bills to: **Medical Claims, Room H-230, SA-1, U.S. Department of State 2401 E St. NW, Washington DC 20522-0102.**
NOTE: Recommend a copy of the examination be given to examinee.

X. ALL TESTS REQUIRED UNLESS OTHERWISE SPECIFIED. PLEASE ATTACH ALL REPORTS. **NAME OF EXAMINEE:**

1. HEMATOLOGY

Hematocrit _____ %
OR
Hemoglobin _____ gms%
WBC _____ /cmm
Differential:
Granulocytes _____ %
Lymphocytes _____ %
Eosinophils _____ %
Other _____ %

2. SCREENING CHEMISTRY *(pre-employment and at least every 5 years).*

Blood Sugar _____
Cholesterol _____
HDL/LDL _____
Triglycerides _____
Creatinine _____
ALT _____
GGT _____
HbA1C *(when indicated)* _____

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

RPR/VDRL _____
HIV I/II antibody _____
HepB surface antigen _____
HepC antibody _____

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).*

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

Specific Gravity _____
Albumin _____
Sugar _____
WBC _____
RBC _____
Casts _____
Other _____

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: _____

10. PULMONARY FUNCTION TEST *(required for overseas postings above 8,000 feet, or when indicated for asthma, COPD, or smokers).*

FVC _____ L, % of predicted _____
FEV1 _____ L, % of predicted _____
FEV1/FVC _____

11. 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 (X-Ray required) Yes ☐ No ☐
Treatment:

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

13. 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 _____

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