



U.S. Department of State
MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053

OMB No. 1405-0113
 EXPIRATION DATE: 01/31/2004
 ESTIMATED BURDEN: 35 minutes
 (See Page 2 - Back of Form)

| | | | |
|-------------------------|-----------------|------------------------|--|
| Name (Last, First, MI) | | Exam Date (mm-dd-yyyy) | |
| Birth Date (mm-dd-yyyy) | Passport Number | Alien (Case) Number | |

1. Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)
 NOTE: The following information has been self-reported, has not been verified by a physician, and should not be deemed medically definitive.

| No | Yes | | No | Yes | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> | General | <input type="checkbox"/> | <input type="checkbox"/> | Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs | |
| <input type="checkbox"/> | <input type="checkbox"/> | Illness or injury requiring hospitalization (including psychiatric) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiology | <input type="checkbox"/> | <input type="checkbox"/> | Obstetrics and Sexually Transmitted Diseases | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy Fundal height _____ cm |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Last menstrual period Date (mm-dd-yyyy) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulmonology | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases, specify _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | History of tobacco use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endocrinology and Hematology |
| | | Current use <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes mellitus |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic obstructive pulmonary disease (emphysema) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of malaria |
| <input type="checkbox"/> | <input type="checkbox"/> | History of tuberculosis (TB) disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other |
| | | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malignancy, specify _____ |
| | | Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic renal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurology and Psychiatry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic hepatitis or other chronic liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | History of stroke, with current impairment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hansen's Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous |
| <input type="checkbox"/> | <input type="checkbox"/> | Major impairment in learning, intelligence, self care, memory, or communication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary |
| <input type="checkbox"/> | <input type="checkbox"/> | Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of drugs other than those required for medical reasons | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visible disabilities (including loss of arms or legs), specify _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Addiction or abuse of specific* substance (drug) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other requiring treatment, specify _____ |
| | | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other substance-related disorders (including alcohol addiction or abuse) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ever taken action to end your life | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

2. Physical Examination (indicate findings and give details in Remarks)

No Yes Applicant appears to be providing unreliable or false information, specify _____

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP _____ / _____ (mmHg) Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

*N, normal; A, abnormal; ND, not done

| N* | A* | ND* | | N* | A* | ND* | |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | General appearance and nutritional status | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inguinal region (including adenopathy) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing and ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Extremities (including pulses, edema) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal system (including gait) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nose, mouth, and throat (include dental) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart (S1, S2, murmur, rub) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lymph nodes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous system (including nerve enlargement) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lungs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental status (including mood, intelligence, perception, thought processes, and behavior during examination) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen (including liver, spleen) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitalia (including circumcision, infection(s)) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

Physical examination or laboratory results contradict medical history

Referral prior to departure. If yes, provide results _____

Referral prior to departure. If yes, provide results _____

4. Follow-up Needed After Arrival

No Yes, within 1 week Yes, within 1 month Yes, within 6 months

For continuing medication, list type, dose, and frequency _____

For continuing other treatment, specify _____

5. Remarks (describe any abnormal history, abnormal findings, and resulting interventions)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 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: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).