Photo

U.S. Department of State

# MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For Use with DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2017
ESTIMATED BURDEN: 30 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

| No | Yes | | No | Yes | |
|---|---|---|---|---|---|
| | | **General** | | | **Obstetrics and Sexually Transmitted Diseases** |
| ☐ | ☐ | Illness or injury requiring hospitalization *(including psychiatric)* | ☐ | ☐ | Pregnancy, current<br>Estimated delivery date *(mm-dd-yyyy)* _____ |
| | | **Cardiology** | ☐ | ☐ | Pregnancy, birth dates *(mm-dd-yyyy)* |
| ☐ | ☐ | Hypertension | | | _____ _____ _____ |
| ☐ | ☐ | Congestive heart failure or coronary artery disease | | | _____ _____ _____ |
| ☐ | ☐ | Arrhythmia | | | |
| ☐ | ☐ | Rheumatic heart disease | | | |
| ☐ | ☐ | Congenital heart disease | | | **Previous treatment for sexually transmitted diseases, specify date *(mm-yyyy)* and treatment:** |
| | | **Pulmonology** | ☐ | ☐ | Chancroid _____ |
| ☐ | ☐ | Tobacco use: ☐ Current ☐ Former | ☐ | ☐ | Gonorrhea _____ |
| ☐ | ☐ | Asthma | ☐ | ☐ | Granuloma inguinale _____ |
| ☐ | ☐ | Chronic obstructive pulmonary disease | ☐ | ☐ | Lymphogranuloma venereum _____ |
| ☐ | ☐ | Tuberculosis history: Diagnosed *(mm-yyyy)* _____<br>Treated *(mm-yyyy)* _____ | ☐ | ☐ | Syphilis _____ |
| ☐ | ☐ | Fever | | | **Endocrinology** |
| ☐ | ☐ | Cough | ☐ | ☐ | Diabetes mellitus |
| ☐ | ☐ | Night sweats | ☐ | ☐ | Thyroid disease |
| ☐ | ☐ | Weight loss | | | **Hematologic/Lymphatic** |
| | | **Psychiatry** | ☐ | ☐ | Anemia |
| ☐ | ☐ | Major impairment in learning, intelligence, self-care, memory, or communication | ☐ | ☐ | Sickle Cell Disease |
| | | | ☐ | ☐ | Thalassemia major |
| ☐ | ☐ | Major mental disorder (including bipolar disorder, major depression, mental retardation, post-traumatic stress disorder, schizoaffective disorder, schizophrenia) | ☐ | ☐ | Other hemoglobinopathy |
| | | | | | **Other** |
| ☐ | ☐ | Use of drugs other than those required for medical reasons | ☐ | ☐ | HIV: if previously tested, mm-yyyy of test _____ |
| ☐ | ☐ | Addiction (dependence) or abuse of specific substances or drugs on the CSA | ☐ | ☐ | Wears glasses or contact lenses |
| | | | ☐ | ☐ | Malignancy, specify: _____ |
| ☐ | ☐ | Other substance related disorders (including alcohol abuse or dependence) | ☐ | ☐ | Chronic renal disease |
| | | | ☐ | ☐ | Chronic liver disease *(including hepatitis)* |
| ☐ | ☐ | 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 | ☐ | ☐ | Hansen's Disease: Diagnosed *(mm-yyyy)* _____<br>Treated *(mm-yyyy)* _____ |
| ☐ | ☐ | Ever had thoughts of harming yourself | ☐ | ☐ | Other medical conditions requiring treatment, specify: |
| ☐ | ☐ | Ever acted on those thoughts | | | _____ |
| ☐ | ☐ | Ever had thoughts of harming others | | | _____ |
| ☐ | ☐ | Ever acted on those thoughts | | | |
| | | | ☐ | ☐ | Disabilities *(including loss of arms or legs)*, specify: |
| | | **Neurology** | | | _____ |
| ☐ | ☐ | History of stroke | | | _____ |
| ☐ | ☐ | Seizure disorder | | | _____ |
| ☐ | ☐ | **Applicant appears to be providing unreliable or false information, specify in remarks** | | | |

**2. Current Medications** *(List all current medications)*

_____

_____

_____

_____

**3. Previous Surgeries** *(List all previous surgeries)*

_____

_____

_____

_____

**4. Vital Signs and Vision**

| | | | |
|---|---|---|---|
| Height _____ cm | BP _____ / _____ | Temperature _____ °C | Visual acuity at 20 feet: |
| Weight _____ kg | Pulse _____ / min | Respiratory Rate _____ / min | Uncorrected L 20/ _____ R 20/ _____ |
| BMI _____ kg/m² | | | Corrected L 20/ _____ R 20/ _____ |

**5. Physical Examination** *(include all findings and give details in Remarks)*

**N, normal; A, abnormal**

| N | A | | N | A | |
|---|---|---|---|---|---|
| ☐ | ☐ | General appearance | ☐ | ☐ | Inguinal region *(including adenopathy)* |
| ☐ | ☐ | Nutritional status *(including acute wasting and or chronic stunting malnutrition)* | ☐ | ☐ | Musculoskeletal system *(including gait)* |
| | | | ☐ | ☐ | Extremities *(including pulses, edema)* |
| ☐ | ☐ | Hearing and ears | ☐ | ☐ | Skin *(including hypopigmentation or anesthesia consistent with Hansen's Disease, evidence of self-inflicted injury or injections)* |
| ☐ | ☐ | Eyes | | | |
| ☐ | ☐ | Nose, mouth, and throat *(include detail)* | ☐ | ☐ | Hematologic *(including signs of anemia such as pallor, koilonychia)* |
| ☐ | ☐ | Heart *(S1, S2, murmur, rub)* | ☐ | ☐ | Lymph nodes |
| ☐ | ☐ | Lungs | ☐ | ☐ | Nervous system *(including nerve enlargement)* |
| ☐ | ☐ | Abdomen *(including liver, spleen)* | ☐ | ☐ | Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)* |
| ☐ | ☐ | Genitalia *(including infection(s))* | | | |

**6. Mental Health Specialist**

☐ Referral made to mental health specialist. If so, attach report.

**7. Syphilis Laboratory Results and Treatment**

☐ Laboratory testing not done

| | Test Name | Date specimen reported *(mm-dd-yyyy)* | Positive | Negative | Initial Titer |
|---|---|---|---|---|---|
| **Screening** | | | | | |
| **Confirmatory** | | | | | |

Treated
☐ Yes
☐ No

If treated, therapy:
☐ Benzathine penicillin, 2.4 MU IM
☐ Other *(therapy, dose)*: _____

Treated by panel physician: ☐ Yes ☐ No

Stage of syphilis *(mark one)*:
☐ Primary
☐ Secondary
☐ Early latent
☐ Late latent or latent of unknown duration
☐ Tertiary
☐ Neurosyphilis
☐ Congenital

Date(s) treatment given *(mm-dd-yyyy)*
_____ _____ _____

**8. Diagnosis and Treatment of Other Sexually Transmitted Infections**

Infection: ☐ Chancroid ☐ Gonorrhea ☐ Granuloma inguinale ☐ Lymphogranuloma venereum

Diagnosed by panel physician: ☐ Yes ☐ No Treated by panel: physician: ☐ Yes ☐ No

| Drug | Dosage | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* |
|---|---|---|---|
| | | | |
| | | | |

**9. Diagnosis and Treatment for Hansen's Disease**

Type of Hansen's Disease

- ☐ Multibacillary
- ☐ Paucibacillary

Treatment

- ☐ Partial
- ☐ Completed

Treated by panel physician

- ☐ Yes
- ☐ No

| Drug | Dosage | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

If not treated by panel physician, was referral made by panel physician to another provider for treatment:

- ☐ Yes. Provide facility name: _____
- ☐ No

Diagnosis

- ☐ Initial diagnosis made by panel physician
- ☐ Initial diagnosis made by non-panel physician before medical evaluation by panel physician

  If so, year of diagnosis: _____

**10. Remarks**

## PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

### PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 30 minutes 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 recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

### CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may, in the discretion of the Secretary of State, be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records.