U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: xx/xx/20xx
ESTIMATED BURDEN: 30 minutes

Photo

Surnames	Given Names	Exam Date *(mm-dd-yyyy)*

Birth Date *(mm-dd-yyyy)*	Document Type	Document Number	Case or Alien Number

1. Medical History (*Past or present*)

No	Yes		No	Yes	
☐	☐	**Applicant appears to be providing unreliable or false information, specify in remarks**	☐	☐	**Obstetrics** Pregnant, on day of exam Estimated delivery date (mm-dd-yyyy) _____ Last Menstrual Period, *LMP* (mm-dd-yyyy) _____
☐	☐	**General** Illness or injury requiring hospitalization *(including psychiatric)*	☐	☐	Previous live births, number: _____ Birth dates of live births (mm-dd-yyyy) _____ _____
☐	☐	**Cardiology** Hypertension			
☐	☐	Congestive heart failure or coronary artery disease			
☐	☐	Arrhythmia			
☐	☐	Rheumatic heart disease			
☐	☐	Congenital heart disease			**Sexually Transmitted Diseases (STDs)** ***Previous treatment for STDs-*** ***Specify date (mm-yyyy) and treatment received:***
☐	☐	**Pulmonology** Tobacco use: ☐ Current ☐ Former	☐	☐	Syphilis _____
☐	☐	Asthma	☐	☐	Gonorrhea _____
☐	☐	Chronic obstructive pulmonary disease	☐	☐	Chlamydia _____
☐	☐	Tuberculosis history: Diagnosed *(mm-yyyy)* _____ Treatment Completed *(mm-yyyy)* _____ *Diagnosed (mm-yyyy)* _____ *Treatment Completed (mm-yyyy)* _____ *Diagnosed (mm-yyyy)* _____ *Treatment Completed (mm-yyyy)* _____	☐	☐	Trichomoniasis _____ Herpes _____ Other STDs (specify): _____ _____
☐	☐	Fever			**Endocrinology**
☐	☐	Cough	☐	☐	Diabetes
☐	☐	Night sweats	☐	☐	Thyroid disease
☐	☐	Weight loss			**Hematologic/Lymphatic**
		Psychiatry	☐	☐	Anemia
☐	☐	Psychological/Psychiatric Disorder (including major depression, bipolar disorder, schizophrenia, gender dysphoria, delusional disorder, etc.)	☐	☐	Sickle Cell Disease
			☐	☐	Thalassemia
			☐	☐	High Cholesterol
			☐	☐	Other hemoglobinopathy
☐	☐	Major impairment in learning, intelligence, self-care, memory, or communication			**Other**
☐	☐	Use of substances other than those required for medical reasons	☐	☐	An abnormal or reactive HIV blood test Date Tested (*mm-yyyy*) _____
☐	☐	Substance use disorder involving a substances on the Controlled Substances Act (CSA)	☐	☐	Malignancy, specify:_____
☐	☐	Substance use disorder involving a substance not on the CSA (including alcohol)	☐	☐	Kidney or Bladder disease
☐	☐	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	☐	☐	Chronic liver disease *(including Hepatitis B or C)*
☐	☐	Ever had thoughts of harming yourself	☐	☐	Hansen's Disease History: *Diagnosed (mm-yyyy)* _____ *Treatment Completion date (mm-yyyy)* _____
☐	☐	Ever acted on those thoughts	☐	☐	Food or drug allergies, specify: _____
☐	☐	Ever had thoughts of harming others	☐	☐	Other medical conditions requiring treatment, specify: _____ _____
☐	☐	Ever acted on those thoughts	☐	☐	Disabilities *(including loss of arms or legs),* specify: _____ _____
		Neurology			
☐	☐	History of stroke			
☐	☐	Seizure disorder			

2. Current Medications *(List all current medications. Use additional sheets, if required.)*

	Name of Medication	**Expected Time to Take Medications** *Short Term = Less than 6 months Medium Term = 6-12 months Long Term = More than 12 months*
1		
2		
3		
4		
5		

3. Previous Surgeries *(List all previous surgeries, including but not limited to those related to other health conditions, heart disease, pregnancy, or elective surgeries to attempt to change male traits to female and vice versa. Use additional sheets, if required.)*

	Surgery
1	
2	
3	
4	
5	

4. Vital Signs and Vision

Height _____ cm
Weight _____ kg
BMI _____ kg/m^2

BP (age 15 and up) _____ / _____
Pulse _____ / min

Temperature _____ °C
Respiratory Rate _____ / min

Visual acuity at 6 meters (age 4 and up):
L 6/ _____ R 6/ _____
☐ Corrected ☐ Uncorrected

5. Physical Examination *(include all findings and give details in Remarks)* ***N, normal; A, abnormal***

N	A		N	A	
☐	☐	General appearance	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	Nutritional status (*including acute malnutrition [wasting] or chronic malnutrition [stunting]*)	☐	☐	Extremities *(including pulses, edema)*
			☐	☐	Skin
☐	☐	Hearing and ears	☐	☐	Hematologic
☐	☐	Eyes	☐	☐	Nervous system: Sequelae of stroke or cerabral palsy, other neurologic disabilities
☐	☐	Nose, mouth, and throat *(include dental)*			
☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*
☐	☐	Lungs (*auscultation*)			
☐	☐	Abdomen *(including liver, spleen)*	☐	☐	Lymph nodes
☐	☐	Fundal height (if applicable): _____			

6. Mental Health

☐ No mental health classification.
☐ Referral made to mental health specialist. If so, attach report.
☐ Any physical or mental disorder or substance use disorder of non-controlled substance, such as alcohol.

☐ Class A, with harmful behavior (current or likely to recur), list disorder(s) and/or non-controlled substances:
_____

☐ Class B, without harmful behavior, list disorder(s) or with past harmful behavior that is unlikely to recur (or in remission), list disorder(s) and/or non-controlled substances:
_____

☐ Substance use disorder of a specific substance on the Controlled Substances Act

☐ Class A, list substance(s) _____

☐ Class B, in remission, list substance(s) _____

Testing for abuse of controlled substances and alcohol (Urine)

Test Name	**Date result reported** *(mm-dd-yyyy)*

☐ **No Substances Detected** ☐ Laboratory Testing Not Done

Check box if the corresponding controlled substances was positively detected. Annotate if inconclusive result or test unavailable.

☐ Amphetamines _____
☐ Barbiturates _____
☐ Benzodiazepines _____
☐ Cocaine Metabolites / Benzoylecgonine _____
☐ Cannabis / Marijuana Metabolites _____
☐ Other: _____
☐ Other: _____

☐ Methadone _____
☐ Buprenorphine _____
☐ Methaqualone _____
☐ Opiates _____
☐ Phencyclidine _____
☐ MDAAnalogues _____
☐ Alcohol: _____

7. Syphilis Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date result reported *(mm-dd-yyyy)*	Reactive	Non-reactive	Titer
Screening					
Confirmatory					

Treated		Date (mm-dd-yyyy)	Date (mm-dd-yyyy)	Date (mm-dd-yyyy)
☐ Yes ☐ No	Benzathine penicillin, 2.4 MU IM			
	Other *(therapy, dose)*: _____			
	Treated by panel physician: ☐ Yes ☐ No			

Stage of syphilis *(mark one)*:

☐ Primary ☐ Tertiary
☐ Secondary ☐ Neurosyphilis
☐ Early latent ☐ Congenital
☐ Late latent or latent of unknown duration

8. Gonorrhea Laboratory Results and Treatment

☐ Laboratory testing not done

	Test Name	Date result reported *(mm-dd-yyyy)*	Positive	Negative
Screening				

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

9. Other Sexually Transmitted Diseases Laboratory Results

☐ Laboratory testing not done

STD Screening	Test Name	Date result reported *(mm-dd-yyyy)*	Positive	Negative
Hepatitis B (Blood)				
Hepatitis C (Blood)				
Herpes (HSV-1/HSV-2 (Blood)				
Chlamydia (Urine)				
Trichomoniasis (Urine)				
HIV / AIDs				
Other STDs (specify): _____				
_____				

10. Diagnosis and Treatment for Hansen's Disease

(Complete this section only if the applicant was diagnosed by the panel physician or was on Hansen's Disease treatment at the time of presentation for his or her examination.)

Type of Hansen's Disease

☐ Multibacillary
☐ Paucibacillary

Treatment

☐ Partial (≥ 7 days)
☐ Completed

Treated by panel physician

☐ Yes
☐ No

Test Name	Date Result Reported	Positive	Negative

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: _____

11. Tattoos, Scars, and Markings

(Submit a photograph of all tattoos, scars, and markings and include a description and where it is located on the body. Use additional sheets, if needed.)

	Description of Tattoo, Scar or Marking	Location on Body
1		
2		
3		
4		
5		

12. Metabolic Lipid Panel

☐ Laboratory testing not done

	Test Name	**Date result reported** *(mm-dd-yyyy)*
Screening		

Lipid Panel	**Result**	*Expected Range*
Total Cholesterol	MG/DL	< 200 MG/DL
Triglycerides	MG/DL	< 150 MG/DL
HDL (High-Density Lipoprotein)	MG/DL	> 39 MG/DL
LDL (Low-Density Lipoprotein)	MG/DL	< 100 MG/DL

13 Remarks *(Attach additional sheets, if needed.)*

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

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INA Section 222(f) provides that visa issuance and refusal records 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. The U.S. Department of State uses the information provided on this form to determine an individual's eligibility for a U.S. visa. Certified copies of visa records may be made available to a court which certifies that the information contained in such records is needed in a case pending before the court. 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. Although furnishing this information is voluntary, individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. visa or experience processing delays.