





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)
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3. SOCIAL SECURITY NUMBER (Employee or Applicant)	4. DATE OF BIRTH (mm-dd-yyyy)	5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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6. PLACE OF BIRTH City _____ Country _____	7. STATUS <input type="checkbox"/> APPLICANT <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER _____
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8. NAME OF YOUR HEALTH INSURANCE PLAN	10a. AGENCY <input type="checkbox"/> State <input type="checkbox"/> USAID <input type="checkbox"/> Other _____
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9. PURPOSE OF EXAM <input type="checkbox"/> PRE-EMPLOYMENT <input type="checkbox"/> SEPARATION <input type="checkbox"/> IN SERVICE	10b. TYPE OF EMPLOYMENT <input type="checkbox"/> Foreign Service Officer <input type="checkbox"/> Contractor <input type="checkbox"/> Civil Service Excursion Tour
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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 _____ _____
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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					
Child					

14. CHECK AND DESCRIBE MEDICAL CONDITIONS OF BLOOD RELATIVES. INCLUDE CANCER, ALCOHOLISM, DIABETES, HEART, OR KIDNEY DISEASE, HIGH BLOOD PRESSURE, MENTAL HEALTH	<input type="checkbox"/> Father _____ <input type="checkbox"/> Mother _____ <input type="checkbox"/> Grandmother(s) _____ <input type="checkbox"/> Grandfather(s) _____ <input type="checkbox"/> Sisters _____ <input type="checkbox"/> Brothers _____ <input type="checkbox"/> Aunts and Uncles _____
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15. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Other	16. ARE YOU ADOPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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**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:																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	49. Have you used marijuana, hallucinogenic drugs, narcotics, or cocaine in the last 10 years? <b>Explain if yes.</b>																																																								
<input type="checkbox"/>	<input type="checkbox"/>	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?																																																								
YES	NO																																																									
<input type="checkbox"/>	<input type="checkbox"/>	If you are past menopause, have you had any vaginal bleeding?																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Any change in your periods, or bleeding between periods? When was your last PAP test? (mm,yyyy) _____																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Have you had an abnormal PAP test in the last 5 years? Date of abnormal PAP test (mm,yyyy). _____ Result _____																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a mammogram? Last date (mm,yyyy)? _____																																																								
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an abnormal mammogram (mm,yyyy)? _____																																																								
<input type="checkbox"/>	<input type="checkbox"/>	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)
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**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 <i>(needed for genetic risk factors)</i> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other <i>(specify)</i> _____	2. HEIGHT _____ in. or _____ cm.	3. WEIGHT _____ lb. or _____ kg.	4. PULSE	5. BLOOD PRESSURE <i>(sitting)</i> If above 140/85 repeat 3 times and record. If consistently elevated consider treatment.
<b>VII. CLINICAL EVALUATION</b> Check each item as indicated. Enter "NE" if not evaluated.		Normal	Abnormal	<b>NOTES</b> <i>(Describe Every Abnormality in Detail. Pertinent Item Number Before Each Comment)</i>
1. Skin <i>(Record Lesions, Body Marks and Surgery Scars)</i>				
2. Head, Neck, Thyroid				
3. Ear, Nose and Throat				
4. Lymph Nodes				
5. Eyes <i>(Include Funduscopic Exam)</i>				
6. Lungs				
7. Breasts				
8. Heart <i>(Record Murmurs and Abnormalities)</i>				
9. Abdomen <i>(Comment on Liver and Spleen)</i>				
10. Genitalia <i>(Male-Testes Descended? Masses?)</i>				
11. Anus, Rectum and Prostate <i>(required at age 40 and over)</i>				
12. Vascular System <i>(Record Peripheral Pulses and Varicosities)</i>				
13. Extremities and Spine				
14. Neurological <i>(Record Reflexes and Muscle Strength)</i>				
15. Psychiatric <i>(Specify Any Significant Mood, Cognitive, Behavioral Observations)</i>				
16. GYN <i>(Bimanual Exam Required for Female Examinees 21 Years and Over, or When Indicated). Describe Abnormalities</i>				
17. Papanicolaou done <input type="checkbox"/> Not done <input type="checkbox"/> Reason if not done				
18. Attach cytology report.				
ADDITIONAL COMMENTS				
VIII. LIST CURRENT MEDICATIONS <i>(Include prescription, over the counter, vitamins, and herbals)</i>				DRUG OR OTHER ALLERGIES
_____				_____
_____				_____
_____				_____
<b>IX. INSTRUCTIONS TO THE EXAMINER</b>				
<b>IMPORTANCE OF EXAMINATION:</b> 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.				
<b>DISPOSITION OF REPORTS:</b> 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: <b>MEDICAL CLEARANCES, Room L209 SA-1, U.S. Department of State, 2401 E St. NW Washington, DC 20522-0102.</b>				
<b>EXAMINATION FEES:</b> 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: <b>Medical Claims, Room H-230, SA-1, U.S. Department of State 2401 E St. NW, Washington DC 20522-0102.</b>				
<b>NOTE:</b> Recommend a copy of the examination be given to examinee.				

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

<b>1. HEMATOLOGY</b> Hematocrit _____ % OR Hemoglobin _____ gms% WBC _____ /cmm Differential: Granulocytes _____ % Lymphocytes _____ % Eosinophils _____ % Other _____ %	<b>4. STOOL EXAM FOR OCCULT BLOOD</b> (50 years or earlier when indicated). a. Pos _____ Neg _____ b. Pos _____ Neg _____ c. Pos _____ Neg _____	<b>8. ECG</b> (50 years or earlier when indicated. All pre-employment 40 years and above. Submit all tracings). Results: _____ <hr/> <b>9. CHEST X-RAY</b> (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: _____	
<b>2. SCREENING CHEMISTRY</b> (pre-employment and at least every 5 years). Blood Sugar _____ Cholesterol _____ HDL/LDL _____ Triglycerides _____ Creatinine _____ ALT _____ GGT _____ HbA1C (when indicated) _____	<b>5. COLON SCREEN</b> (age 50 or when indicated by risk factors according to current standards of care). FFS, Barium Enema, or Colonoscopy. Attach most recent results.	<b>10. PULMONARY FUNCTION TEST</b> (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 _____	<b>12. MAMMOGRAM</b> (required age 50 years and over, recommended age 40 and over).
<b>3. SEROLOGY</b> (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 _____	<b>6. PSA</b> (50 years or earlier when indicated). <hr/> <b>7. URINALYSIS</b> (pre-employment, separation and when indicated). Specific Gravity _____ Albumin _____ Sugar _____ WBC _____ RBC _____ Casts _____ Other _____	<b>11. TUBERCULIN TEST</b> (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: _____	<b>13. PRE-EMPLOYMENT AND IN SERVICE IF NOT PREVIOUSLY DONE</b> (not for separation) a. Blood Type ABO _____ (Rh) D _____ (weak) D <sup>u</sup> _____ b. G6PD Normal _____ Deficient _____

<b>XI. ASSESSMENT OR PROBLEM LIST</b>	<b>XII. RECOMMENDATION FOR TREATMENT/FURTHER STUDY/CONSULTATION OR FOLLOW-UP</b>
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<b>TYPED NAME OF EXAMINER</b>	<b>SIGNATURE</b>	<b>DATE</b> (mm-dd-yyyy)
<b>EXAMINING FACILITY</b> Telephone Number _____ Fax Number _____	<b>ADDRESS</b>	