



MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

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	
<input type="checkbox"/>	<input type="checkbox"/>	Applicant appears to be providing unreliable or false information, specify in remarks	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics
<input type="checkbox"/>	<input type="checkbox"/>	General Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant, on day of exam Estimated delivery date (mm-dd-yyyy) _____ LMP _____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiology Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Previous live births, number: _____ Birth dates of live births (mm-dd-yyyy) _____
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure or coronary artery disease			
<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease			
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease			Sexually Transmitted Diseases Previous treatment for sexually transmitted diseases, specify date (mm-yyyy) and treatment:
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonology Tobacco use: <input type="checkbox"/> Current <input type="checkbox"/> Former	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis _____ Gonorrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology Diabetes _____ Thyroid disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic Anemia _____ Sickle Cell Disease _____ Thalassemia _____ Other hemoglobinopathy _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis history: Diagnosed (mm-yyyy) _____ Treatment Completed (mm-yyyy) _____ Diagnosed (mm-yyyy) _____ Treatment Completed (mm-yyyy) _____ Diagnosed (mm-yyyy) _____ Treatment Completed (mm-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Other An abnormal or reactive HIV blood test Diagnosed (mm-yyyy) _____ Malignancy, specify: _____ Kidney or Bladder disease _____ Chronic liver disease (including hepatitis B or C) _____ Hansen's Disease History: Diagnosed (mm-yyyy): _____ Treatment Completed (mm-yyyy) _____ Food or drug allergies, specify: _____ Other medical conditions requiring treatment, specify: _____ Disabilities (including loss of arms or legs), specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever			
<input type="checkbox"/>	<input type="checkbox"/>	Cough			
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats			
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss			
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry Psychological/Psychiatric Disorder (including major depression, bipolar disorder, or schizophrenia)			
<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self-care, memory, or communication			
<input type="checkbox"/>	<input type="checkbox"/>	Use of substances other than those required for medical reasons			
<input type="checkbox"/>	<input type="checkbox"/>	Substance use or substance induced disorders of substances on the Controlled Substances Act (CSA)			
<input type="checkbox"/>	<input type="checkbox"/>	Substance use or substance induced disorders of substances not on the CSA (including alcohol)			
<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"/>	Ever had thoughts of harming yourself			
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts			
<input type="checkbox"/>	<input type="checkbox"/>	Ever had thoughts of harming others			
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts			
<input type="checkbox"/>	<input type="checkbox"/>	Neurology History of stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder			

2. Current Medications (List all current medications)

3. Previous Surgeries (List all previous surgeries)

4. Vital Signs and Vision Height _____ cm Weight _____ kg	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/ _____ <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected
--	---	--	---

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

N, normal; A, abnormal

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

6. Mental Health Specialist

No mental health classification

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

Any physical or mental disorder (excluding addiction or abuse of specific substance on the Controlled Substances Act but including other substance-related disorder)

Class A, with harmful behavior, list disorder(s) _____

Class B, without harmful behavior, list disorder(s) _____

Addiction or abuse of a specific substance on the Controlled Substances Act

Class A, list substance(s) _____

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

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)	Stage of syphilis (mark one):	
<input type="checkbox"/> Yes	Benzathine penicillin, 2.4 MU IM			<input type="checkbox"/> Primary	<input type="checkbox"/> Tertiary
<input type="checkbox"/> No	Other (therapy, dose): _____			<input type="checkbox"/> Secondary	<input type="checkbox"/> Neurosyphilis
Treated by panel physician: <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Early latent	<input type="checkbox"/> Congenital
				<input type="checkbox"/> 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. 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 their medical examination

- Type of Hansen's Disease Treatment
- Multibacillary Partial (≥ 7 days)
- Paucibacillary Completed

	Test Name	Date Result Reported	Positive	Negative
Drug	Dosage	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)	

- Treated by panel physician
- Yes
- No

- 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 15 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

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.