

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

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

For use with DS-2053

| | |
|------------------------|------------------------|
| 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 history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

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| <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">No</td> <td style="width:10%;">Yes</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>General</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Illness or injury requiring hospitalization (including psychiatric)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Angina pectoris</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hypertension (high blood pressure)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiac arrhythmia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Congenital heart disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pulmonology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tobacco use</td> </tr> <tr> <td></td> <td></td> <td> Current use <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic obstructive pulmonary disease (emphysema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tuberculosis (TB) disease</td> </tr> <tr> <td></td> <td></td> <td> Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td></td> <td></td> <td> Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurology and Psychiatry</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of stroke, with current impairment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Seizure disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major impairment in learning, intelligence, self care, memory, or communication</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Use of drugs other than those required for medical reasons</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Addiction or abuse of specific* substance (drug)</td> </tr> <tr> <td></td> <td></td> <td> *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other substance-related disorders (including alcohol addiction or abuse)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ever taken action to end your life</td> </tr> </table> | No | Yes | | <input type="checkbox"/> | <input type="checkbox"/> | General | <input type="checkbox"/> | <input type="checkbox"/> | Illness or injury requiring hospitalization (including psychiatric) | <input type="checkbox"/> | <input type="checkbox"/> | Cardiology | <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Pulmonology | <input type="checkbox"/> | <input type="checkbox"/> | History of tobacco use | | | Current use <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Chronic obstructive pulmonary disease (emphysema) | <input type="checkbox"/> | <input type="checkbox"/> | History of tuberculosis (TB) disease | | | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | Neurology and Psychiatry | <input type="checkbox"/> | <input type="checkbox"/> | History of stroke, with current impairment | <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder | <input type="checkbox"/> | <input type="checkbox"/> | Major impairment in learning, intelligence, self care, memory, or communication | <input type="checkbox"/> | <input type="checkbox"/> | Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) | <input type="checkbox"/> | <input type="checkbox"/> | Use of drugs other than those required for medical reasons | <input type="checkbox"/> | <input type="checkbox"/> | Addiction or abuse of specific* substance (drug) | | | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics | <input type="checkbox"/> | <input type="checkbox"/> | Other substance-related disorders (including alcohol addiction or abuse) | <input type="checkbox"/> | <input type="checkbox"/> | Ever taken action to end your life | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">No</td> <td style="width:10%;">Yes</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>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</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Obstetrics and Sexually Transmitted Diseases</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pregnancy Fundal height _____ cm</td> </tr> <tr> <td></td> <td></td> <td> Last menstrual period Date (mm-dd-yyyy) _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexually transmitted diseases, specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Endocrinology and Hematology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes mellitus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Thyroid disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of malaria</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Malignancy, specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic renal disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic hepatitis or other chronic liver disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hansen's Disease</td> </tr> <tr> <td></td> <td></td> <td> <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous</td> </tr> <tr> <td></td> <td></td> <td> OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary</td> </tr> <tr> <td></td> <td></td> <td> Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Visible disabilities (including loss of arms or legs), specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other requiring treatment, specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> </table> | No | Yes | | <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"/> | Obstetrics and Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy Fundal height _____ cm | | | Last menstrual period Date (mm-dd-yyyy) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases, specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Endocrinology and Hematology | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes mellitus | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | History of malaria | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> | Malignancy, specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | Chronic renal disease | <input type="checkbox"/> | <input type="checkbox"/> | Chronic hepatitis or other chronic liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Hansen's Disease | | | <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous | | | OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary | | | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> | <input type="checkbox"/> | Visible disabilities (including loss of arms or legs), specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other requiring treatment, specify _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| No | Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Illness or injury requiring hospitalization (including psychiatric) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiology | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac arrhythmia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulmonology | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | History of tobacco use | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Current use <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic obstructive pulmonary disease (emphysema) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | History of tuberculosis (TB) disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurology and Psychiatry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | History of stroke, with current impairment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Major impairment in learning, intelligence, self care, memory, or communication | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of drugs other than those required for medical reasons | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Addiction or abuse of specific* substance (drug) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other substance-related disorders (including alcohol addiction or abuse) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ever taken action to end your life | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <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"/> | Obstetrics and Sexually Transmitted Diseases | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy Fundal height _____ cm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Last menstrual period Date (mm-dd-yyyy) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases, specify _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrinology and Hematology | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | History of malaria | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignancy, specify _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic renal disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic hepatitis or other chronic liver disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hansen's Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Treated <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Visible disabilities (including loss of arms or legs), specify _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other requiring treatment, specify _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <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"/> | Genitalia (including circumcision, infection(s)) | | | | |

