



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)

Photo

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	
<input type="checkbox"/>	<input type="checkbox"/>	General Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics and Sexually Transmitted Diseases Pregnancy, current Estimated delivery date (mm-dd-yyyy) _____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiology Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, birth dates (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			
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonology Tobacco use: <input type="checkbox"/> Current <input type="checkbox"/> Former	<input type="checkbox"/>	<input type="checkbox"/>	Previous treatment for sexually transmitted diseases, specify date (mm-yyyy) and treatment:
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chancroid _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis history: Diagnosed (mm-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Granuloma inguinale _____
		Treated (mm-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Lymphogranuloma venereum _____
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis _____
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry Major impairment in learning, intelligence, self-care, memory, or communication	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic
<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including bipolar disorder, major depression, mental retardation, post-traumatic stress disorder, schizoaffective disorder, schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Addiction (dependence) or abuse of specific substances or drugs on the CSA	<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia major
<input type="checkbox"/>	<input type="checkbox"/>	Other substance related disorders (including alcohol abuse or dependence)	<input type="checkbox"/>	<input type="checkbox"/>	Other hemoglobinopathy
<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"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Ever had thoughts of harming yourself	<input type="checkbox"/>	<input type="checkbox"/>	HIV: if previously tested, mm-yyyy of test _____
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Wears glasses or contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	Ever had thoughts of harming others	<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ever acted on those thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver disease (including hepatitis)
			<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease: Diagnosed (mm-yyyy) _____
					Treated (mm-yyyy) _____
			<input type="checkbox"/>	<input type="checkbox"/>	Other medical conditions requiring treatment, specify: _____ _____
			<input type="checkbox"/>	<input type="checkbox"/>	Disabilities (including loss of arms or legs), specify: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurology History of stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder			
<input type="checkbox"/>	<input type="checkbox"/>	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/m ²			Corrected L 20/ _____ R 20/ _____	

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"/>	Inguinal region (including adenopathy)
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional status (including acute wasting and or chronic stunting malnutrition)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation or anesthesia consistent with Hansen's Disease, evidence of self-inflicted injury or injections)
<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include detail)	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic (including signs of anemia such as pallor, koilonychia)
<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
<input type="checkbox"/>	<input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/> No	If treated, therapy:		Date(s) treatment given (mm-dd-yyyy)		
	<input type="checkbox"/> Benzathine penicillin, 2.4 MU IM		_____		
	<input type="checkbox"/> Other (therapy, dose): _____				
	Treated by panel physician: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Stage of syphilis (mark one):					
<input type="checkbox"/> Primary		<input type="checkbox"/> Tertiary			
<input type="checkbox"/> Secondary		<input type="checkbox"/> Neurosyphilis			
<input type="checkbox"/> Early latent		<input type="checkbox"/> Congenital			
<input type="checkbox"/> Late latent or latent of unknown duration					

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 Treatment
- Multibacillary Partial
- Paucibacillary Completed

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 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.