U.S. Department of State
美国国务院

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT
移民或难民医学检查

OMB No. 1405-0113
EXPIRATION DATE: 04/30/2012
表格有效期至:2012 年 04 月 30 日
ESTIMATED BURDEN: 10 minutes
完成表格估计耗时: 10 分钟
(See Page 2 – Back of Form)
(见第二页)

For use with TB Technical Instructions 2007 and the DS-3030　　与 2007 结核技术指导和 DS-3030 表同时使用

Photo

Name *(Last, First, MI)*
姓名 (姓,名) _____ , _____ , _____

Birth Date *(mm-dd-yyyy)*
出生日期 *(月-日-年)* _____

SEX: ☐ **M** ☐ **F**
性别: 男 女

Birthplace *(City/County)*
出生地 *(城市/国家)* _____ / _____

Present Country of Residence
现居住国 _____

Prior Country
原居住国 _____

U.S. Consul *(City/Country)*
美领所在地 *(城市/国家)* _____ / _____

Passport Number
护照号码 _____

Alien *(Case)* **Number**
档案号码 _____

Date of Medical Exam *(Date of TB physical exam or date of lab report of final TB culture results, if cultures perfomed)(mm-dd-yyyy)*
医学检查的日期*（结核体检日期或如有结核培养时，最后培养的实验室报告日期）* *(月-日-年)* _____

Date Exam Expires *(3 months if Class A TB, Class A HIV, or Class B1, otherwise 6 months) (mm-dd-yyyy)*
体检结果有效截止日期 *(A 级结核、A 级人类免疫缺陷病毒感染或 B1 级结核为 3 个月，否则为 6 个月)（月-日-年）* _____

Date *(mm-dd-yyyy)* **of Prior Exam, if any**
如曾检查过,注明上次检查日期*(月-日-年)* _____

Exam Place *(City/Country)*
体检地点*(城市/国家)* _____ / _____

Panel Physician
主检医生 _____

Radiology Services
放射学检查机构 _____

Screening Site *(name)*
体检医院 *(名称)* _____

Lab *(name for HIV/syphilis/TB)*
实验室名称*(人类免疫缺陷病毒/梅毒/结核)* _____ / _____ / _____

(1) **Classification** *(check all boxes that apply):*
分类 *(在相应方格内打勾)*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3025, DS-3026 and DS-3030)*
无明显损害、疾病或残废 *(见 DS-3025, DS-3026 和 DS-3030 表)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*
A 级病症 *(根据过去史和体检表的内容判断)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
  活动性结核,具传染性 *(根据胸部 X 光检查情况定为 A 级)*
- ☐ Syphilis, untreated
  梅毒，未治疗
- ☐ Chancroid, untreated
  软下疳，未治疗
- ☐ Gonorrhea, untreated
  淋病，未治疗
- ☐ Granuloma inguinale, untreated
  腹股沟肉芽肿，未治疗
- ☐ Lymphogranuloma venereum, untreated
  淋巴肉芽肿，未治疗
- ☐ Human immunodeficiency virus (HIV)
  人类免疫缺陷病毒
- ☐ Hansen's disease, untreated multibacillary
  麻风病，未治疗的多菌型
- ☐ Addiction or abuse of specific* substance without harmful behavior
  对某些特殊*物质成瘾或滥用，但无伤害行为
- ☐ Any physical or mental disorder *(including other substance-related disorder)* with harmful behavior or history of such behavior likely to recur
  任何生理或精神异常*(包括与其它物质相关的异常)*并且有伤害行为或历史上曾有伤害行为，现在有可能复发

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
*安非它明，大麻，可卡因，致幻剂，吸入剂，鸦片类，循环苯吡啶，镇静－催眠药和抗焦虑药

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*
B 级病症 *(根据过去史和体检表的内容判断)*

- ☐ Syphilis (with residual deficit), treated within the last year
  梅毒 *(有残留的病征)*，一年内曾治疗过
- ☐ Other sexually transmitted infections, treated within last year
  其他的性传播疾病，一年内曾治疗过
- ☐ Current pregnancy, number of weeks pregnant _____
  目前正怀孕，妊娠周数
- ☐ Any physical or mental disorder *(excluding addiction or abuse of specific* substance but including other substance-related disorder)* without harmful behavior or history of such behavior unlikely to recur
  任何生理或精神异常*（不包括对特殊*物质的成瘾或滥用，但存在与其它物质相关的异常）*，无伤害行为或历史上曾有伤害行为，但不会再发作。
- ☐ Hansen's disease, treated multibacillary
  麻风病，已治疗的多菌型
  Treatment: ☐ Partial ☐ Completed
  治疗： 部分完成 完成治疗
- ☐ Hansen's disease, paucibacillary
  麻风病，少量排菌型
  Treatment: ☐ None ☐ Partial ☐ Completed
  治疗： 未治疗 部分完成 完成治疗
- ☐ Sustained, full remission of addiction or abuse of specific* substances
  曾持续使用某些特殊*物质，但现已停用

* amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids,phencyclidines, sedative-hypnotics, and anxiolytics
* 安非它明，大麻，可卡因，致幻剂，吸入剂，鸦片类，循环苯吡啶，镇静－催眠药和抗焦虑药

☐ **Class B1 TB, Pulmonary**
B1 级肺结核

☐ No treatment
未治疗

☐ Completed treatment (check all that apply and attach all laboratory and DOT documents)
完成治疗（在所有相应方格内打勾并附上所有实验室和直接面试督导下治疗的资料）

☐ By panel physician
由主签名医生完成

☐ By non-panel physician
非主签名医生完成

☐ Initial smear positive
初次痰涂片阳性

☐ Initial culture positive
初次痰培养阳性

☐ Pre-treatment culture and DST results performed/available
已进行/已提供治疗前培养和药敏试验的结果

☐ Pre-treatment culture and/or DST results not performed/available
未进行/未提供治疗前培养和/或药敏试验的结果

☐ **Class B1 TB, Extrapulmonary**
B1 级肺外结核

Anatomic Site of Disease
患病部位 _____

☐ No treatment 未治疗

☐ Current treatment 正在治疗

☐ Completed treatment 完成治疗

☐ **Class B2 TB, LTBI Evaluation**
B2 级结核，潜伏性结核感染评估

☐ Test for TB infection positive
结核感染试验阳性:

☐ TST _____ mm
结核菌素皮试 _____ 毫米

☐ IGRA positive Result
γ-干扰素释放试验阳性 结果 _____

☐ TST or IGRA Conversion
结核菌素皮试或 γ-干扰素释放试验转化

☐ No LTB1 treatment
未进行预防性治疗

☐ Current LTB1 treatment *(Indicate medications in Part 4 of DS-2054 from)* 正接受预防性治疗
（在 DS-2054 表的第 4 部分注明治疗药物）

☐ Completed LTB1 treatment *(Indicate medications in Part 4 of DS-2054 from)*
已完成预防性治疗（在 DS-2054 表的第 4 部分注明治疗药物）

☐ **Class B3 TB, Contact Evaluation B3 级结核，接触者评估**

☐ TST _____ mm
结核菌素皮试 毫米

☐ IGRA negative
γ-干扰素释放试验阴性

☐ IGRA positive
γ-干扰素释放试验阳性

IGRA Result _____
γ-干扰素释放试验结果

☐ No preventive treatment
未进行预防性治疗

☐ Current preventive treatment *(Indicate medications in Part 4 of DS-2054 form)*
正接受预防性治疗（在 DS-2054 表的第 4 部分注明治疗药物）

☐ Completed preventive treatment (*Indicate medications in Part 4 of DS-2054 form*)
已完成预防性治疗（在 DS-2054 表的第 4 部分注明治疗药物）

Source Case
结核病源:

Name
姓名 _____

Alien Number
档案号码 _____

Relationship to Contact
与接触者的关系 _____

Date Contact Ended *(mm-dd-yyyy)*
接触终止日期（月－日－年）_____

Type of Source Case TB *(Mark only one and **ATTACH DST RESULTS**)*
结核病源的类型*（仅选其一并附上**药敏试验结果**）*

☐ Pansusceptible TB
对所有治疗药物敏感的结核

☐ MDR TB (resistant to at least INH and rifampin)
耐多药结核（至少对异烟肼和利福平有耐药性）

☐ Drug-resistant TB other than MDR TB
耐多药结核以外的耐药性结核

☐ Culture negative
培养阴性

☐ Culture results not available
不能提供培养结果

☐ **Class B Other** *(specify or give details on checked conditions from worksheets)*
B 级其它类*（详细说明体检表中打勾的异常情况）*

⑵ **Laboratory Findings** *(check all boxes that apply)*
实验室检查发现（*在相应的方格内打勾*）：

Syphilis
梅毒： ☐ **Not done** **未做**

	Test name 检验项目名称	Date(s) run *(mm-dd-yyyy)* 检验日期（*月-日-年*）	Negative 阴性	Positive 阳性	Titer 1 滴度 1	Notes 备注
Screening 筛查			☐	☐		
Confirmatory 确认			☐	☐		

Treated 治疗过
☐ Yes 是
☐ No 否

If treated, therapy:
如接受过治疗，所用疗法
☐ Benzathine penicillin, 2.4 MU IM
苄星青霉素 240 万单位，肌注
☐ Other *(therapy, does)*:
其他（*疗法，剂量*）:

Dates(s) treatment given *(mm-dd-yyyy) (3 doses for penicillin)*
给予治疗的日期（*3 次治疗剂量青霉素*）

_____ _____ _____

HIV
人类免疫缺陷病毒： ☐ **Not done** **未做**

	Test name 检验项目名称	Date(s) run *(mm-dd-yyyy)* 检验日期（*月-日-年*）	Negative 阴性	Positive 阳性	Indeterminate 不确定	Notes 备注
Screening 筛查			☐	☐	☐	
Secondary 再查			☐	☐	☐	
Confirmatory 确认			☐	☐	☐	

⑶ **Immunizations** *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**
预防接种（*参见预防接种记录表，在相应方格内打勾*） **难民不要求填写此栏目**。

☐ Vaccine history complete
过去已完成接种

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*
过去未完成接种，符合豁免要求（*在以下相应类型打勾*）

☐ Incomplete vaccine history, no waiver requested
过去未完成接种，不符合豁免要求

☐ Blanket waiver
表中所指豁免项目

☐ Individual waiver
个人原因需豁免项目

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.
我证明我了解该医学检查的目的并且授权医生完成所要求的检测。

Applicant Signature 申请人签名	Panel Physician Signature 主检医生签名	Date (mm-dd-yyyy) 日期(月-日-年)

⑷ **Tuberculosis Treatment Regimen** **结核治疗方案**

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown")
（如果申请人曾经或正在服用治疗结核的药物，请填写以下内容。如果不知道或不能提供药物的剂量或治疗日期，标注"不知道"）

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*
如果目前正按规定治疗请打勾（*如正在治疗，不用注明"结束治疗的日期"*）

Medication 药物	Dose/Interval (i.e. mg/day) 剂量/间隔 (例如：毫克/日)	Start Date *(mm-dd-yyyy)* 开始治疗的日期 （*月-日-年*）	End Date *(mm-dd-yyyy)* 结束治疗的日期 （*月-日-年*）
☐ Isonaizid (INH) 异烟肼			
☐ Rifampin 利福平			
☐ Pyrazinamide 吡嗪酰胺			
☐ Ethambutol 乙胺丁醇			
☐ Streptomycin 链霉素			

☐ Other, specify
其它，详细说明

Applicant's pre-treatment weight (kg)
申请人治疗前的体重（公斤）

Date *(mm-dd-yyyy)*
日期(月-日-年)

Remarks 备注:

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES
文字报告缩减法和个人隐私法之相关通告

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information required, 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: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

针对表中的要求对资料进行搜集并根据所得资料完成此表，估计每份平均需要 10 分钟。若持表人所提交的表上无美国预算和管理局的有效号码，这类人无需向您提供表中的相关信息。若您对于完成表格所需时间的估计和表格内容的精简有更好的建议，请发送到：A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT 机密性声明

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 Sates 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 be made available to a court provided the court certifies that the information contained in such records in needed in a case pending before the court.

授权 此表信息的搜集是依据移民及国籍法第212(a)、221(d)和222条的要求。第222（f）条规定美国国务院和外事处、领事处有关允许或拒绝进入美国的签证记录应予以保密，并且只在制订、修正、执行或实施美国移民法、国籍法和其它法规时允许使用。如果法院证明在待处理案例上庭受理前需要用到这些记录所含信息，法院可使用这些记录的公证材料。

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.

目的 美国国务院根据您在此表所提供信息决定您的级别分类和是否有资格获得美国移民签证。不递交此表或不按要求提供所需全部信息的申请人可能无法获得美国移民签证。虽然完成此表是自愿的，但不按要求提供相关信息会延迟或妨碍签证申请的受理。

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.

常规使用 如果您获得了移民签证并作为移民进入美国，国土安全部将按此表信息给您签发永久居民卡，并且，如果您需要，社会安全管理局也将据此授予您一个社会安全号码。此表信息也可能会提供给执法、反恐和维护国土安全的联邦机构；美国国会和法院管辖范围内的机构；以及需要这些信息实施或执行美国法律的其它联邦机构。

U.S. Department of State
美国国务院

CHEST X-RAY AND CLASSIFICATION WORKSHEET
胸部 X 光检查和疾病分类表

For use with TB TI 2007 and the DS-2054 与 2007 结核技术指导和 DS-2054 表同时使用

Complete Sections 1 through 5, As Applicable 根据需要完成第 1 至 5 部分

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(See Page 2-Back of Form)
（见表后第二页）

Name *(Last, First, MI)* 姓名（*姓，名*）	**Age** 年龄

Birth Date *(mm-dd-yyyy)* 出生日期（*月-日-年*）	**Passport Number** 护照号码	**Alien (Case) Number** 档案号

1. Chest X-Ray Indication *(Mark all that apply)*
胸部 X 光检查指征（*在所有相应方格内打勾*）

☐ Age ≥ 15 years
年龄≥15 岁

Test for TB infection
结核感染的试验:

☐ Signs or symptoms of tuberculosis
结核的体征或症状

☐ TST≥ 10mm;
结核菌素皮试≥ 10mm

Result mm; Date *(mm-dd-yyyy)*
结果 _____ 毫米 日期（*月-日-年*）_____

☐ HIV infection
人类免疫缺陷病毒感染

☐ IGRA Positive;
γ－干扰素释放试验阳性

Result_____ Date *(mm-dd-yyyy)*_____
结果 日期（*月-日-年*）

(If child does not have any of the above, stop here)
（若未成年申请人没有上述指征可不填写以下内容）

2. Chest X-Ray Findings
胸部 X 光检查结果

Date Chest X-Ray Taken *(mm-dd-yyyy)*
胸部 X 光检查日期（*月-日-年*）_____

☐ Normal Findings
结果正常

☐ Abnormal Findings *(Indicate category and finding, checking all that apply in the table below.)*
结果异常 （*在下面异常类别和异常情况相对应的方格内打勾*）

☐ **Can Suggest Tuberculosis** ***(Need Smears and Cultures)*** **疑似结核**（***需痰涂片和培养***）		☐ **Other X-Ray Findings** **其它 X 光所见**
☐ Infiltrate or Consolidation 渗出或实变	☐ Discrete linear opacity (fibrotic scar) 散在的条索状混浊影（纤维化病灶）	☐ Follow-Up Needed (Mark as Class B Other) 需要随访(标识为 B 级其它类)
☐ Any cavitary lesion 任何空洞样病损	☐ Discrete nodule*(s)* without calcification 散在的无钙化结节	☐ Musculoskeletal 肌肉骨骼疾病
☐ Nodule or mass with poorly defined margins （Such as Tuberculoma） 边界不清的结节或块状影 （*如结核球*）	☐ Discrete linear opacity (fibrotic scar) with volume loss or retraction 散在的条索状混浊影(纤维化病灶)并肺容量大量丧失	☐ Cardiac 心血管疾病
☐ Pleural effusion* 胸腔积液	☐ Other *(Such as bronchiectasis)* 其它（*如支气管扩张*）	☐ Pulmonary, non-TB (e.g., emphysema) 肺部疾病，非结核（如肺气肿）
☐ Hilar/mediastinal adenopathy with or without atelectasis 肺门和纵隔淋巴结病变伴或不伴肺不张		☐ Other 其它
☐ Other *(Such as miliary findings)* 其他（*如粟粒型肺结核*） * If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound. 若分不清是胸腔积液或胸膜增厚，加作侧位片或卧位片，或定向超声检查。		☐ No follow-up needed of pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph node(s) with calcified pulmonary nodule(s), or minor musculoskeletal findings. 胸膜增厚、横膈幕状粘连、肺部钙化结节、钙化淋巴结、钙化淋巴结伴肺部钙化结节或轻微的肌肉骨骼病变不需随访。

Remarks
备注

_____ Radiologist's Signature 放射科医生签名

_____ Date Interpreted *(mm-dd-yyyy)* *报告日期（月-日-年）*

TURN PAGE OVER TO FINGSH DS-3030 FORM 转至下页完成 DS-3030 表

3.Sputum Smears and Cultures
痰涂片和培养

☐ No, not indicated-Applicant has no signs or symptoms of TB, no HIV infection, and
未做，不符合指征－申请人没有结核的体征或症状、没有免疫缺陷病毒感染，而且:

☐ X-ray Normal and test for TB infection negative (if performed): this is No Class
X 光所见正常并且结核感染试验阴性（若已做）：无级别

☐ X-Ray Normal and test for TB infection positive (if performed): this is Class B2 TB, LTB1 Evaluation
X 光所见正常并且结核感染试验阳性（若已做）：B2 级结核，潜伏性结核感染评估

☐ Yes, are indicated – Applicant has (Mark all that apply)
已做，符合指征－申请人具有（在所有相应方格内打勾）:

☐ Signs or symptoms of TB
结核的体征或症状

☐ Chest X-ray suggests TB
胸部 X 光所见疑似结核

☐ HIV infection
免疫缺陷病毒感染

Sputum Smear Results 痰涂片结果

Date Obtained *(mm-dd-yyyy)* 取痰日期*（月-日-年）*	Positive 阳性	Negative 阴性

Sputum Culture Results 痰培养结果

Date obtained*(mm-dd-yyyy)* 取痰日期*（月-日-年）*	Positive 阳性	Negative 阴性	NTM* 非结核分枝杆菌	Contaminated 污染样本

*Nontuberculous Mycobacteria
非结核分枝杆菌

☐ Positive Smear or Culture Result; this is a Class A TB
痰涂片或培养阳性；A 级结核

☐ Negative Smear and Culture Results and:
痰涂片和培养阴性，而且：

☐ Chest X-Ray suggests TB or sings and symptoms of TB: Class B1 TB, Pulmonary
胸部 X 光所见疑似结核或有结核的体征和症状：B1 级肺结核

☐ HIV infection with normal X-ray and no signs and symptoms of TB: No Class for TB (but must mark on DS-2054 as Class A for HIV)
免疫缺陷病毒感染，但 X 光所见正常而且没有结核的体征和症状：无结核级别 （DS-2054 表上必须标识为 A 级免疫缺陷病毒感染）

4. Classifications *(Mark all that apply and also provide complete information on the DS-2054)*
分级*（在所有相应方格内打勾并在 DS-2054 上提供完整信息）*

☐ No Class
无级别

☐ Class A TB
A 级结核

☐ Class A TB with waiver
豁免的 A 级结核

☐ Class B1 TB, Pulmonary
B1 级肺结核

☐ Class B1, TB, Extrapulmonary
B1 级肺外结核

☐ Class B2, TB, LTBI Evaluation
B2 级结核，潜伏性结核感染评估

☐ Class B3, TB, Contact Evaluation
B3 级结核，接触者评估

☐ Class B Other
B 级其它类别

5. Remarks
备注

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

文字报告缩减法和个人隐私法之相关通告

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针对表中的要求对资料进行搜集并根据所得资料完成此表，估计每份平均需要 10 分钟。若持表人所提交的表上无美国预算和管理局的有效号码，这类人无需向您提供表中的相关信息。若您对于完成表格所需时间的估计和表格内容的精简有更好的建议，请发送到：A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT 机密性声明

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授权 此表信息的搜集是依据移民及国籍法第212(a)、221(d)和222条的要求。第222（f）条规定美国国务院和外事处、领事处有关允许或拒绝进入美国的签证记录应予以保密，并且只在制订、修正、执行或实施美国移民法、国籍法和其它法规时允许使用。如果法院证明在待处理案例上庭受理前需要用到这些记录所含信息，法院可使用这些记录的公证材料。

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.

目的 美国国务院根据您在此表所提供信息决定您的级别分类和是否有资格获得美国移民签证。不递交此表或不按要求提供所需全部信息的申请人可能无法获得美国移民签证。虽然完成此表是自愿的，但不按要求提供相关信息会延迟或妨碍签证申请的受理。

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.

U.S. Department of State
美国国务院

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

医学病史和身体检查表

For use with DS-2053 or DS-2054　　与 DS-2053 表或 DS-2054 一同使用

OMB No.1405-0113
EXPIRATION DATE: 04/30/2012
表格有效期至 2012 年 04 月 30 日
ESTIMATED BURDEN: 35minutes
完成表格估计耗时:35 分钟
(See Page 2-Back of form)
(见第二页)

Name *(Last, First, MI)* 姓名(*姓，名*)		**Exam Date** *(mm-dd-yyyy)* 检查日期(*月-日-年*)
Birth Date *(mm-dd-yyyy)* 出生日期(*月-日-年*)	**Passport Number** 护照号码	**Alien (Case) Number** 档案号码

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

过去病史　*(若存在定居后需要药物或其它治疗的病症应标明并在备注栏内详细说明)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

注: 以下病史由申请人陈述，尚未经医生所证实，不应作为医学结论

No 否	Yes 是	General 一般情况
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)* 需要住院治疗的疾病或外伤*（含精神疾病）*
		Cardiology **心脏疾病**
☐	☐	Angina pectoris 心绞痛
☐	☐	Hypertension (high blood pressure) 高血压
☐	☐	Cardiac arrhythmia 心律不齐
☐	☐	Congenital heart disease 先天性心脏病
		Pulmonology **肺部疾病**
☐	☐	History of tobacco use 吸烟史 Current use ☐ Yes ☐ No 现仍吸烟　是　否
☐	☐	Asthma 哮喘
☐	☐	Chronic obstructive pulmonary disease *(emphysema)* 慢性阻塞性肺部疾病*(肺气肿)*
☐	☐	History of tuberculosis *(TB)* disease 结核病史 Treated ☐ Yes ☐ No 治疗过　是　否 Current TB symptoms ☐ Yes ☐ No 目前有结核症状　是　否
		Neurology and Psychiatry **神经和精神疾病**
☐	☐	History of stroke, with current impairment 中风史,现有后遗症
☐	☐	Seizure disorder 癫痫
☐	☐	Major impairment in learning, intelligence, self care, memory or communication 在学习、智力、自理能力、记忆力或社交方面存在严重缺陷
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)* 精神障碍*(包括重型抑郁症，双相情感障碍，精神分裂症，智力缺陷)*
☐	☐	Use of drugs other than those required for medical reasons 非医疗原因使用药物
☐	☐	Addiction or abuse of specific* substance *(drug)* 对特殊*物质*（药物）*成瘾或滥用 * amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics * 安非它明，大麻，可卡因，致幻剂，吸入剂，鸦片类，循环苯吡啶，镇静－催眠药和抗焦虑药
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)* 与其它物质有关的异常*（包括酒精依赖或酗酒）*
☐	☐	Ever taken action to end your life 曾经有自杀行为

No 否	Yes 是	
☐	☐	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. 因受到患病、精神障碍、酒精或药物等因素影响，曾导致他人重伤，造成严重财产损失或触犯法律
		Obstetrics and Sexually Transmitted Diseases **产科状况及性病**
☐	☐	Pregnancy　Fundal height _____cm 妊娠　宫底高度 Last menstrual period Date *(mm-dd-yyyy)* 末次月经时间:*（月-日-年）* _____
☐	☐	Sexually transmitted diseases, specify 性传播疾病，详细说明_____
		Endocrinology and Hematology **内分泌疾病和血液系统疾病**
☐	☐	Diabetes mellitus 糖尿病
☐	☐	Thyroid disease 甲状腺疾病
☐	☐	History of malaria 疟疾病史
		Other **其它**
☐	☐	Malignancy, specify 恶性病，详细说明_____
☐	☐	Chronic renal disease 慢性肾脏疾病
☐	☐	Chronic hepatitis or other chronic liver disease 慢性肝炎或其他慢性肝脏疾病
☐	☐	Hansen's Disease 麻风病 ☐ Multibacillary　☐ Paucibacillary 多种杆菌感染　排菌量少 Treated ☐ Yes ☐ No 治疗过　是　否
☐	☐	Visible disabilities *(including loss of arms or legs)* 可见残障*（包括上肢或下肢缺失）* Specify 详细说明_____
☐	☐	Other requiring treatment, specify 其它需要治疗的状况，详细说明_____

2. Physical Examination *(indicate findings and give details in Remarks)*
身体检查 *（注明体检所见并于备注内详细说明）*

☐ No 否 ☐ Yes 是 Applicant appears to be providing unreliable or false information, specify
申请人的临床表现与其所提供的信息不吻合或其所提供的信息有误，详细说明

Height 身高 _____cm | Weight 体重_____kg | Visual Acuity at 20 feet: 20 英尺处视力: | Uncorrected 裸眼视力 | L 20/ 左 20/_____ | R20/ 右 20/_____

BP 血压_____/_____(mmHg) 毫米汞柱 | Heart rate 心率 _____ /min /分 | Respiratory rate 呼吸频率 _____/min /分 | Corrected 矫正视力 | L 20/ 左 20/_____ | R20/ 右 20/_____

* **N, normal; A, abnormal; ND, not done**
正常 不正常 未做

N*	A*	ND*		N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status 外观特征及营养状况	☐	☐	☐	Inguinal region *(including adenopathy)* 腹股沟区*（含腺体病变情况）*
☐	☐	☐	Hearing and ears 听力及双耳	☐	☐	☐	Extremities *(including pulses, edema)* 肢体*（含脉搏和水肿情况）*
☐	☐	☐	Eyes 双眼	☐	☐	☐	Musculoskeletal system *(including gait)* 肌肉骨骼系统*（含步态）*
☐	☐	☐	Nose, Mouth, and throat (include dental) 鼻、口腔和咽喉（包括牙齿）	☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)* 皮肤*（含色素沉着不足、感觉缺失、自伤或自行注射的痕迹）*
☐	☐	☐	Heart *(S1, S2, murmur, rub)* 心脏*（第 1 心音、第 2 心音、杂音、摩擦音）*				
☐	☐	☐	Breast 乳腺	☐	☐	☐	Lymph nodes 淋巴结
☐	☐	☐	Lungs 肺	☐	☐	☐	Nervous system *(including nerve enlargement)* 神经系统*（含神经束肿大表现）*
☐	☐	☐	Abdomen *(including liver, spleen)* 腹部*（包括肝、脾）*	☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)* 精神状况*（含检查期间的情绪、智力、知觉、思维逻辑和行为）*
☐	☐	☐	Genitalia *(including circumcision, infection(s))* 生殖器*（包括包皮或阴蒂环切术，传染病）*				

3. Additional Testing Needed Prior to Approving Medical Clearance
出国前需要加做检查以便确诊

No 否 Yes 是

☐ ☐ Physical examination or laboratory results contradict medical history
体检或检验室检测结果与病史矛盾

☐ ☐ Referral prior to departure if yes, provide results
如果在出国前接受了会诊，结论是：_____

☐ ☐ Referral prior to departure if Yes, provide results
如果在出国前接受了会诊，结论是：_____

4. Follow-up Needed After Arrival
到美国后需要随访

☐ No 否 ☐ Yes, within 1 week 是，1 周内 ☐ Yes, within 1 month 是，1 个月内 ☐ Yes, within 6 months 是，6 个月内

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medication, use Part 4 of DS-2053 or DS-2054 form)*
需继续药物治疗，列出药物的类别、剂量和服用次数 *(例外：结核药物治疗填写在 DS-2053 表或 DS-2054 表的第 4 部分)* _____

☐ For continuing other treatment, specify
需继续其它治疗，详细说明 _____

5.Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*
备注 *（描述过去病史、体检中异常发现和结论）*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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常规使用 如果您获得了移民签证并作为移民进入美国，国土安全部将按此表信息给您签发永久居民卡，并且，如果您需要，社会安全管理局也将据此授予您一个社会安全号码。此表信息也可能会提供给执法、反恐和维护国土安全的联邦机构；美国国会和法院管辖范围内的机构；以及需要这些信息实施或执行美国法律的其它联邦机构。

U. S Department of State
美国国务院

VACCINATION DOCUMENTATION WORKSHEET

预防接种记录表

For Use with DS-2053 or DS-2054 与 DS-2053 或 DS-2054 表一同使用　　To Be Completed by Panel Physician Only　只能由主检医生完成

OMB No.1405-0113
EXPIRATION DATE: 04/30/2012
表格有效期至: 2012 年 4 月 30 日
ESTIMATED BURDEN:30 Minutes
完成表格估计耗时:30 分钟
(See Page 2-Back of Form)
(见第二页)

Name *(Last, First, MI)* 姓名 (*姓，名*)			Exam Date *(mm- dd - yyyy)* 检查日期 *(月-日-年)*
Birth Date *(mm- dd - yyyy)* 出生日期 *(月-日-年)*	Passport Number 护照号码	Alien (Case) Number 档案号	**REQUIRED FOR U. S. IMMIGRANT VISA APPLICANTS** 赴美移民签证申请人要求完成此表 **NOT REQUIRED FOR REFUGEE APPLICANTS** 难民不要求完成此表 **NOTE FOR PANEL PHYSICIANS:** 主检医生请注意:

1. Immunization Record
预防接种记录

Vaccine History Transferred From a Written Record
(List Chronologically from Left to Right)
将书面记录的预防接种史转载到下栏中
(按时间顺序从左到右)

Vaccine 疫苗	Date Received *(mm-dd-yyyy)* 接种时间 *(月-日-年)*	Date Received *(mm-dd-yyyy)* 接种时间 *(月-日-年)*	Date Received *(mm-dd-yyyy)* 接种时间 *(月-日–年)*	Date Received *(mm-dd-yyyy)* 接种时间 *(月-日-年)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)* 主检医生实施接种的时间*(月-日-年)*	Completed Series *(✓ if completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)* 完成了系列接种*(若完成了接种，在格内打"✓";若申请人有水痘病史,则注明"VH"或写下实验室检测确认已获得免疫力的日期)*	Not Age Appropriate 年龄不适合	Insufficient Time Interval 时间间隔不当	Contra-indicated 有禁忌症	Not Routinely Available 无疫苗常规供应	Not Fall (Flu) Season 非接种季节
Specify *(check)* vaccine: 注明所用疫苗（打勾）: ☐DTaP 无细胞百白破 ☐DTP 百白破 ☐DT 白破											
Specify *(check)* vaccine: 注明所用疫苗（打勾）: ☐Td 成人白破 ☐Tdap 成人百白破											
Specify (check) vaccine: 注明所用疫苗（打勾）: ☐Polio-OPV 口服脊髓灰质炎 ☐ IPV 灭活脊髓灰质炎											
Specify (check) vaccine: 注明所用疫苗（打勾）: ☐MMR(Measles-Mumps-Rubella) 麻腮风 ☐Rubella 风疹											
Specify (check) vaccine: 注明所用疫苗（打勾）: ☐Measles 麻疹 ☐Measles-Rubella 麻疹--风疹二联											
Specify (check) vaccine: 注明所用疫苗（打勾）: ☐Mumps 腮腺炎 ☐Mumps-Rubella 腮腺炎--风疹二联											
Rotavirus 轮状病毒											
Hib 流感嗜血杆菌 B 型											

For refugee applicants, please complete only if reliable vaccination documents are available
若申请人是难民,只有当申请人出示有效的预防接种文件时医生才填写此表

Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below
若不能对申请人实施所要求的疫苗接种,请在下列相应项目中打勾

Hepatitis A 甲型肝炎											
Hepatitis B 乙型肝炎											
Meningococcal 脑膜炎球菌											
Human papillomavirus 人乳头状瘤病毒											
Varicella 水痘											
Zoster 带状疱疹											
Pneumococcal 肺炎双球菌											
Influenza 流行性感冒											

2. Results 结论

☐ **Vaccine History Incomplete**
过去未完成接种

☐ **Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate** (*as Indicated Above*).
申请人因医学原因不适宜接种*(见上)*

☐ **Applicant will request an individual waiver based on religious or moral convictions.**
申请人因宗教或道德观念等原因要求不接种

☐ **Vaccine history complete for each vaccine, all requirements met** (*Documented Above*).
申请人完成了所有接种要求*(见上)*

☐ **Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.**
申请人未完成所有接种要求，*因无豁免理由,申请人仍需接种一种或多种疫苗*

3. Panel Physician *(Name)*
主检医生*(姓名)* _____

Panel Physician *(Signature)*
主检医生*(签名)*_____

Date *(mm-dd-yyyy)*
日期 *(月-日-年)* _____

Give copy to applicant 将复印件交申请人

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文字报告缩减法和个人隐私法之相关通告

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information required, 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: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

针对表中的要求对资料进行搜集并根据所得资料完成此表，估计每份平均需要 10 分钟。若持表人所提交的表上无美国预算和管理局的有效号码，这类人无需向您提供表中的相关信息。若您对于完成表格所需时间的估计和表格内容的精简有更好的建议，请发送到：A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

CONFIDENTIALITY STATEMENT 机密性声明

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 Sates 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 be made available to a court provided the court certifies that the information contained in such records in needed in a case pending before the court.

授权 此表信息的搜集是依据移民及国籍法第212(a)、221(d)和222条的要求。第222（f）条规定美国国务院和外事处、领事处有关允许或拒绝进入美国的签证记录应予以保密，并且只在制订、修正、执行或实施美国移民法、国籍法和其它法规时允许使用。如果法院证明在待处理案例上庭受理前需要用到这些记录所含信息，法院可使用这些记录的公证材料。

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.

目的 美国国务院根据您在此表所提供信息决定您的级别分类和是否有资格获得美国移民签证。不递交此表或不按要求提供所需全部信息的申请人可能无法获得美国移民签证。虽然完成此表是自愿的，但不按要求提供相关信息会延迟或妨碍签证申请的受理。

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.

常规使用 如果您获得了移民签证并作为移民进入美国，国土安全部将按此表信息给您签发永久居民卡，并且，如果您需要，社会安全管理局也将据此授予您一个社会安全号码。此表信息也可能会提供给执法、反恐和维护国土安全的联邦机构；美国国会和法院管辖范围内的机构；以及需要这些信息实施或执行美国法律的其它联邦机构。