



U. S. Department of State
**MEDICAL EXAMINATION FOR
IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113
EXPIRATION DATE: 1/31/2004
ESTIMATED BURDEN: 40 minutes
(See Page 2 - Back of Form)

Photo

Name (Last, First, MI) _____

Birth Date (mm-dd-yyyy) _____

SEX: ☐ M ☐ F

Birthplace (City/Country) _____

Present Country of Residence _____

Prior Country _____

U. S. Consul (City/Country) _____

Passport Number _____

Alien (Case) Number _____

Date Exam Expires (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy) _____

Exam Place (City/Country) _____

Panel Physician (name) _____

Radiology Services (name) _____

Screening Site (name) _____

Lab (name for HIV/syphilis/TB) _____

(1) Classification (check all boxes that apply):

☐ No apparent defect, disease, or disability (see Worksheets DS-3024, DS-3025 and DS-3026)

☐ Class A Conditions (From Past Medical History and Physical Examination Worksheets)

☐ TB, active, infectious (Class A, from Chest X-Ray Worksheet)

☐ Syphilis, untreated

☐ Chancroid, untreated

☐ Gonorrhea, untreated

☐ Granuloma inguinale, untreated

☐ Lymphogranuloma venereum, untreated

☐ Human immunodeficiency virus (HIV)

☐ Hansen's disease, lepromatous or multibacillary

☐ Addiction or abuse of specific* substance without harmful behavior

☐ Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ Class B Conditions (From Past Medical History and Physical Examination Worksheets)

☐ TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet)

Treatment: ☐ None ☐ Partial ☐ Completed

☐ TB, inactive (Class B2, from Chest X-Ray Worksheet)

Treatment: ☐ None ☐ Partial ☐ Completed

☐ Syphilis, treated within last year

☐ Other sexually transmitted infections, treated within last year

☐ Current pregnancy, number of weeks pregnant _____

☐ Other (specify or give details on checked conditions from worksheets) _____

☐ Hansen's disease, prior treatment

☐ Hansen's disease, tuberculoid, borderline, or paucibacillary

☐ Sustained, full remission of addiction or abuse of specific* substances

☐ 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

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

(2) Laboratory Findings (check all boxes that apply):

Syphilis: ☐ Not done

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		
Treated	If treated, therapy:				Dates(s) treatment given (3 doses for penicillin)	
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM					
☐ No	☐ Other (therapy, dose):					

HIV: ☐ Not done

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(3) Immunizations (See Vaccination Form, check all boxes that apply) Not required for refugee applicants.

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver (indicate type below)

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver

☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature

Panel Physician Signature

Date (mm-dd-yyyy)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 40 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: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).



U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

OMB No. 1405-0113
EXPIRATION DATE: 01/31/2004
ESTIMATED BURDEN: 45 minutes
(See Page 2 - Back of Form)

For Use with DS-2053

Complete Sections 1 through 5, As Applicable

Name (Last, First, MI)		Age												
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number												
1. Chest X-Ray Needed (mark all that apply) ☐ History of tuberculosis (TB) disease ☐ Contact with TB patient ☐ TB signs or symptoms ☐ Adult (with or without any of the other) <i>(If child does not have any of the above, stop here)</i>														
2. Chest X-Ray Findings ☐ Normal findings ☐ Abnormal finding (indicate findings and interpretation, checking all that apply, and any other in table below) Date Chest X-Ray taken (mm-dd-yyyy) _____ <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"><thead><tr><th style="width: 33%; padding: 5px;">☐ Can suggest ACTIVE TB (Need smears)</th><th style="width: 33%; padding: 5px;">☐ Can suggest INACTIVE TB (Need smears if symptomatic)</th><th style="width: 33%; padding: 5px;">☐ OTHER X-ray findings</th></tr></thead><tbody><tr><td style="vertical-align: top; padding: 5px;">☐ Infiltrate or consolidation ☐ Any cavitory lesion ☐ Nodule with poorly defined margins (such as tuberculoma) ☐ Pleural effusion ☐ Hilar/Mediastinal adenopathy ☐ Linear, interstitial markings ☐ Other (such as miliary findings)</td><td style="vertical-align: top; padding: 5px;">☐ Discrete fibrotic scar or linear opacity ☐ Discrete nodule(s) without calcification ☐ Discrete fibrotic scar with volume loss or retraction ☐ Discrete nodule(s) with volume loss or retraction ☐ Other (such as bronchiectasis)</td><td style="vertical-align: top; padding: 5px;">☐ Follow-up needed ☐ Musculoskeletal ☐ Cardiac ☐ Pulmonary ☐ Other ☐ No follow-up needed for Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding</td></tr></tbody></table> Remarks			☐ Can suggest ACTIVE TB (Need smears)	☐ Can suggest INACTIVE TB (Need smears if symptomatic)	☐ OTHER X-ray findings	☐ Infiltrate or consolidation ☐ Any cavitory lesion ☐ Nodule with poorly defined margins (such as tuberculoma) ☐ Pleural effusion ☐ Hilar/Mediastinal adenopathy ☐ Linear, interstitial markings ☐ Other (such as miliary findings)	☐ Discrete fibrotic scar or linear opacity ☐ Discrete nodule(s) without calcification ☐ Discrete fibrotic scar with volume loss or retraction ☐ Discrete nodule(s) with volume loss or retraction ☐ Other (such as bronchiectasis)	☐ Follow-up needed ☐ Musculoskeletal ☐ Cardiac ☐ Pulmonary ☐ Other ☐ No follow-up needed for Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding						
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3. Sputum Smears ☐ No. applicant has no signs or symptoms of TB and: ☐ Yes. applicant has (mark all that apply): ☐ Signs or symptoms of TB present, See Section 1 ☐ X-ray suggests ACTIVE TB, See Section 2 ☐ X-ray suggests INACTIVE TB, this is a Class B2/TB ☐ OTHER X-ray findings suggest follow-up needed after arrival, this is B Other ☐ OTHER X-ray findings suggest no followup needed, this is No Class ☐ X-ray Normal, this is No Class and smear results are: <table style="width: 100%; border-collapse: collapse;"><thead><tr><th style="width: 30%; text-align: center;">Positive</th><th style="width: 30%; text-align: center;">Negative</th><th style="width: 40%; text-align: left;">Dates obtained (mm/dd/yyyy)</th></tr></thead><tbody><tr><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td>_____</td></tr><tr><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td>_____</td></tr><tr><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td>_____</td></tr></tbody></table>			Positive	Negative	Dates obtained (mm/dd/yyyy)	☐	☐	_____	☐	☐	_____	☐	☐	_____
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☐	☐	_____												
☐	☐	_____												
☐	☐	_____												
Sputum smear results and X-ray findings: At least one smear result POSITIVE and ☐ Any chest X-ray finding, this is Class A/TB (Normal or Abnormal findings) Three smear results NEGATIVE and ☐ X-ray Normal with ☐ Signs of symptoms resolved, this is No Class ☐ Signs or symptoms suggest follow-up needed after arrival, this is B Other ☐ X-ray suggests ACTIVE or INACTIVE TB, this is Class B1/TB ☐ OTHER X-ray findings suggest follow-up needed after arrival, this is Class B Other														
4. ☐ No Class ☐ Class A/TB ☐ Class B1/TB ☐ Class B2/TB ☐ Class B Other, follow-up needed														
5. Follow-up Needed After Arrival ☐ No ☐ Yes If Yes, for ☐ Not TB condition ☐ TB condition. <i>(If yes, specify condition below and on DS-2053; include additional tests, and therapy used with start and stop dates and any changes)</i> Remarks _____ _____ _____														

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 45 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: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

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U.S. Department of State
MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET
For use with DS-2053

OMB No. 1405-0113
EXPIRATION DATE: 01/31/2004
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

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 information has been self-reported, has not been verified by a physician, and should not be deemed medically definitive.				
<table border="0" style="width:100%;"><tr><td style="width:50%; vertical-align: top; padding-right: 10px;"> ☐ No ☐ Yes General ☐ Illness or injury requiring hospitalization (including psychiatric) Cardiology ☐ Angina pectoris ☐ Hypertension (high blood pressure) ☐ Cardiac arrhythmia ☐ Congenital heart disease Pulmonology ☐ History of tobacco use Current use ☐ Yes ☐ No ☐ Asthma ☐ Chronic obstructive pulmonary disease (emphysema) ☐ History of tuberculosis (TB) disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No Neurology and Psychiatry ☐ History of stroke, with current impairment ☐ Seizure disorder ☐ Major impairment in learning, intelligence, self care, memory, or communication ☐ Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) ☐ Use of drugs other than those required for medical reasons ☐ Addiction or abuse of specific* substance (drug) *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics ☐ Other substance-related disorders (including alcohol addiction or abuse) ☐ Ever taken action to end your life ☐ No ☐ Yes 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 Obstetrics and Sexually Transmitted Diseases ☐ Pregnancy Fundal height _____ cm Last menstrual period Date (mm-dd-yyyy) _____ ☐ Sexually transmitted diseases, specify _____ Endocrinology and Hematology ☐ Diabetes mellitus ☐ Thyroid disease ☐ History of malaria Other ☐ Malignancy, specify _____ ☐ Chronic renal disease ☐ Chronic hepatitis or other chronic liver disease ☐ Hansen's Disease ☐ Tuberculoid ☐ Borderline ☐ Lepromatous OR ☐ Paucibacillary ☐ Multibacillary Treated ☐ Yes ☐ No ☐ Visible disabilities (including loss of arms or legs), specify _____ ☐ Other requiring treatment, specify _____ </td></tr></table>			☐ No ☐ Yes General ☐ Illness or injury requiring hospitalization (including psychiatric) Cardiology ☐ Angina pectoris ☐ Hypertension (high blood pressure) ☐ Cardiac arrhythmia ☐ Congenital heart disease Pulmonology ☐ History of tobacco use Current use ☐ Yes ☐ No ☐ Asthma ☐ Chronic obstructive pulmonary disease (emphysema) ☐ History of tuberculosis (TB) disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No Neurology and Psychiatry ☐ History of stroke, with current impairment ☐ Seizure disorder ☐ Major impairment in learning, intelligence, self care, memory, or communication ☐ Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) ☐ Use of drugs other than those required for medical reasons ☐ Addiction or abuse of specific* substance (drug) *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics ☐ Other substance-related disorders (including alcohol addiction or abuse) ☐ Ever taken action to end your life ☐ No ☐ Yes 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 Obstetrics and Sexually Transmitted Diseases ☐ Pregnancy Fundal height _____ cm Last menstrual period Date (mm-dd-yyyy) _____ ☐ Sexually transmitted diseases, specify _____ Endocrinology and Hematology ☐ Diabetes mellitus ☐ Thyroid disease ☐ History of malaria Other ☐ Malignancy, specify _____ ☐ Chronic renal disease ☐ Chronic hepatitis or other chronic liver disease ☐ Hansen's Disease ☐ Tuberculoid ☐ Borderline ☐ Lepromatous OR ☐ Paucibacillary ☐ Multibacillary Treated ☐ Yes ☐ No ☐ Visible disabilities (including loss of arms or legs), specify _____ ☐ Other requiring treatment, specify _____	
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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				
<table border="0" style="width:100%;"><tr><td style="width:50%; vertical-align: top; padding-right: 10px;"> ☐ N* ☐ A* ☐ ND* ☐ General appearance and nutritional status ☐ Hearing and ears ☐ Eyes ☐ Nose, mouth, and throat (include dental) ☐ Heart (S1, S2, murmur, rub) ☐ Breast ☐ Lungs ☐ Abdomen (including liver, spleen) ☐ Genitalia (including circumcision, infection(s)) </td><td style="width:50%; vertical-align: top;"> ☐ N* ☐ A* ☐ ND* ☐ Inguinal region (including adenopathy) ☐ Extremities (including pulses, edema) ☐ Musculoskeletal system (including gait) ☐ Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections) ☐ Lymph nodes ☐ Nervous system (including nerve enlargement) ☐ Mental status (including mood, intelligence, perception, thought processes, and behavior during examination) </td></tr></table>			☐ N* ☐ A* ☐ ND* ☐ General appearance and nutritional status ☐ Hearing and ears ☐ Eyes ☐ Nose, mouth, and throat (include dental) ☐ Heart (S1, S2, murmur, rub) ☐ Breast ☐ Lungs ☐ Abdomen (including liver, spleen) ☐ Genitalia (including circumcision, infection(s))	☐ N* ☐ A* ☐ ND* ☐ Inguinal region (including adenopathy) ☐ Extremities (including pulses, edema) ☐ Musculoskeletal system (including gait) ☐ Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections) ☐ Lymph nodes ☐ Nervous system (including nerve enlargement) ☐ Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
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3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week

☐ Yes, within 1 month

☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency _____

☐ For continuing other treatment, specify _____

5. Remarks (describe any abnormal history, abnormal findings, and resulting interventions)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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VACCINATION DOCUMENTATION WORKSHEET

For Use with OS-2053
To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 1/31/2004
ESTIMATED BURDEN: 30 minutes
(See Page 2 - Back of Form)

Name (Last, First, MI)		Exam Date (mm-dd-yyyy)		Passport Number		Alien (Case) Number																																																																																																									
1. Immunization Record Vaccine History Transferred From a Written Record (list chronologically from left to right) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Vaccine</th> <th style="width: 15%;">Date received (mm/dd/yyyy)</th> <th style="width: 15%;">Date received (mm/dd/yyyy)</th> <th style="width: 15%;">Date received (mm/dd/yyyy)</th> <th style="width: 15%;">Date received (mm/dd/yyyy)</th> <th style="width: 15%;">Vaccine Given by Panel Physician (mm/dd/yyyy)</th> <th style="width: 15%;">Completed Series (✓ if completed, write "VH" if varicella history, or write date of lab test if immune)</th> <th style="width: 15%;">Blanket Waiver(s) To Be Medically Appropriate, Check Suitable Box(es) Below</th> </tr> </thead> <tbody> <tr> <td>DT/DTP/DaP</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Td</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Polio (OPV/IPV)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Measles</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mumps (or MMR)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rubella (or MR or MMR)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hib (Haemophilus influenzae type b)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hepatitis B</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Varicella</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pneumococcal</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Influenza</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>								Vaccine	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)	Date received (mm/dd/yyyy)	Vaccine Given by Panel Physician (mm/dd/yyyy)	Completed Series (✓ if completed, write "VH" if varicella history, or write date of lab test if immune)	Blanket Waiver(s) To Be Medically Appropriate, Check Suitable Box(es) Below	DT/DTP/DaP								Td								Polio (OPV/IPV)								Measles								Mumps (or MMR)								Rubella (or MR or MMR)								Hib (Haemophilus influenzae type b)								Hepatitis B								Varicella								Pneumococcal								Influenza															
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2. Results ☐ Vaccine history incomplete ☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate (as indicated above). ☐ Applicant will request an individual waiver based on religious or moral convictions. ☐ Vaccine history complete for each vaccine, all requirements met (documented above). ☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.																																																																																																															
3. Panel Physician (name) _____ Panel Physician (signature) _____ Date (mm/dd/yyyy) _____																																																																																																															

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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 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: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for the information on this form in the case of applicants for immigrant visas to determine medical eligibility under INA Sections 212(a) and 221(d) and as required by INA Section 212(g)(2). If an immigrant visa is issued, you will convey this form to the INS for disclosure to the Center for Disease Control and the Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If your Immigrant visa is not issued, this form will be treated as confidential under INA Section 222(f).